

4-16-2026

Experiences of Maternal Care in the Gypsy, Roma, and Traveller population in the United Kingdom: A Cultural Care Model

Sarah Englebert Crowson
Walden University

Follow this and additional works at: <https://scholarworks.waldenu.edu/dissertations>



Part of the [Public Health Commons](#)

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Health Sciences and Public Policy

This is to certify that the doctoral dissertation by

Sarah Englebert Crowson

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee

Dr. Magdeline Aagard, Committee Chairperson, Public Health Faculty

Dr. Michael McNickle, Committee Member, Public Health Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2026

Abstract

Experiences of Maternal Care in the Gypsy, Roma, and Traveller population in the

United Kingdom: A Cultural Care Model

by

Sarah Englebert Crowson

MPH, Regis College, 2021

BA, Thomas Edison State University, 2019

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

May 2026

Abstract

Gypsy, Roma, and Traveller women (GRT) in the United Kingdom face persistent maternal health disparities and show poor engagement with healthcare services. Exclusion, discrimination, and a lack of cultural competence from healthcare professionals contribute to poor health outcomes including preterm births; and GRT women have more babies born with congenital anomalies than non-GRT women in the United Kingdom. The purpose of this focused ethnographic qualitative study was to explore how self-identified GRT women living in the United Kingdom experienced maternal care and how cultural identity and social structures influenced their interactions with healthcare providers based on Madeleine Leininger's cultural care theory. Data were collected via semistructured interviews from 14 participants who self-identified as GRT and who had given birth at least once in the United Kingdom in the past 3 years. Findings showed that participants defined maternal health as a culturally learned sense of maternal responsibility that existed within a family led system that operated alongside U.K. National Health Services. Participants described their experiences with maternal health services as a series of conditional care actions shaped by perceived stigma (fear of judgment), surveillance (feeling scrutinized by systems and professionals), and familiarity (greater ease when care felt known and continuous). Together, these factors shaped whether encounters felt respectful and whether participants felt safe asking questions and following care plans. The analysis identified information that healthcare professionals can use to deliver culturally congruent care, which may improve maternal health outcomes.

Experiences of Maternal Care in the Gypsy, Roma, and Traveller population in the
United Kingdom: A Cultural Care Model

by

Sarah Englebert Crowson

MPH, Regis College, 2021

BA, Thomas Edison State University, 2019

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Public Health

Walden University

May 2026

Dedication

This dissertation is dedicated to my mother, Kimberly Beth Brewer Englebert. My mom was my constant support for every moment in my life and my biggest cheerleader. She always knew that one day I would achieve my PhD. I began this journey a few months after she passed, but knowing how much this would mean to her carried me through. I wish that I could share this achievement with you, but I know I wouldn't be where I am without you. This is our achievement together.

Acknowledgments

My academic journey has been long, and it has only been possible because of the steadfast support of my family, friends, and teachers. Their guidance and encouragement made this dissertation possible.

My time at Walden has been the highlight of my academic career, and my committee, Dr. Magdeline Aagard and Dr. Michael McNickle, are shining examples of what mentorship can be. Dr. McNickle, thank you for your steady support and for arriving each time with thoughtful insights and questions that strengthened this work. Dr. Aagard, your encouragement, kindness, and belief in me from the moment we met carried me through. This dissertation is what it is because of you, and I am profoundly grateful.

My world is richer because of the people who surround me. Stacy, Meredith, and Cat, thank you for lifting me up and celebrating every success; I love you. Dr. Francisco Ojeda, thank you for being both mentor and friend, your belief in me has meant more than I can say.

To my family, who endured years of long days, stressful rewrites, and the worry that comes with it all: thank you for standing by me. To my son Marshall, you may be right that I'll be in school doing degrees forever, love you! Matt, my loving husband, thank you for making space for my work and giving me what I needed to achieve my dreams, I love you. Last but certainly not least, the one who has been by my side always and provides the most comfort, my sweet cat Tudor. You are the best.

Table of Contents

List of Tables	vi
List of Figures	vii
Chapter 1: Introduction to the Study.....	1
Introduction.....	1
Background	2
Problem Statement	4
The Purpose of the Study	5
Research Questions.....	5
Theoretical Framework for the Study.....	6
Nature of the Study	7
Definitions.....	8
Assumptions.....	8
Scope and Delimitations	9
Limitations	10
Significance.....	10
Summary	11
Chapter 2: Literature Review	13
Introduction.....	13
Literature Search Strategy.....	14
Maternal Health and Inequalities	15
United Kingdom Maternal Health Trends	15

Maternal Health in Minority and Marginalized Populations	17
The GRT Population: Background and Health Context	23
Historical and Sociocultural Background of the GRT Population.....	23
Health Inequalities in the GRT population	28
Maternal Health in the GRT Population	30
Key Barriers to Maternal Health Access for GRT Women	36
Cultural Barriers and Mistrust in Health Systems	36
Structural and Systemic Barriers	40
Existing Interventions and Frameworks for Maternal Health.....	42
Public Health Initiatives.....	42
Indigenous Health Model.....	45
Theoretical Framework.....	45
Cultural Care Theory	46
Use in Previous Studies	52
Application to Research Questions.....	53
Identified Gaps in the Literature	55
Summary and Conclusions	56
Chapter 3: Research Method.....	60
Introduction.....	60
Research Design and Rationale	60
Role of the Researcher	63
Methodology	65

Participant Selection Logic	65
Instrumentation	65
Procedures for Recruitment, Participation, and Data Collection	66
Data Analysis Plan	69
Issues of Trustworthiness.....	70
Ethical Procedures	72
Summary	73
Chapter 4: Results	75
Introduction.....	75
Study Setting.....	76
Demographics	76
Data Collection	79
Participants and Sampling.....	79
Data Collection Instrument.....	80
Interview Process	81
Data Analysis	82
Data Organization	82
Two-Cycle Coding Approach.....	82
Data Saturation.....	85
Discrepant Cases.....	85
Evidence of Trustworthiness.....	86
Credibility	86

Dependability	87
Confirmability.....	87
Transferability.....	88
Study Results	88
Theme 1	89
Theme 2	92
Theme 3	98
Theme 4	102
Theme 5	106
Research Questions.....	108
Summary	110
Chapter 5: Discussion, Conclusions, and Recommendations.....	112
Introduction.....	112
Interpretation of the Findings.....	113
Comparison to the Literature	114
Applicability of Findings to CCT	117
Cultural Care Preservation and Maintenance	118
Cultural Care Accommodation and Negotiation.....	120
Sunrise Enabler Model.....	124
Kinship and Social Factors	126
Cultural Values and Lifeways.....	127
Religious and Philosophical Factors.....	128

Technological Factors.....	129
Educational Factors.....	129
Economic Factors.....	130
Political and Legal Factors.....	131
Environmental Factors.....	131
Generic (Folk) and Professional Care Systems	132
Limitations of the Study.....	133
Recommendations.....	134
Implications.....	135
Conclusion	137
References.....	139
Appendix A: Digital Recruitment Poster.....	155
Appendix B: Physical Recruitment Poster.....	156
Appendix C: Interview Protocol.....	157
Appendix D: Application of interview questions with the CCT core concepts.....	162
Appendix E: Codes, Categories, and Themes along with RQ association	163
Appendix F: Copyright Permission for Figure 1	167

List of Tables

Table 1 Demographics	77
Table 2. Summary Demographic and Characteristics Statistics	79
Table 3. Categories and Themes	84
Table 4. Application of interview questions to Sunrise Enabler Model arms	162
Table 5. Application of interview questions to CCT core concepts	162
Table 6. Codes, Categories, and Themes	163

List of Figures

Figure 1. Sunrise Enabler Model	51
Figure 2. GRT Maternal Health Sunrise Enabler Model	126

Chapter 1: Introduction to the Study

Introduction

In this study, I explored the experiences of maternal healthcare among women in the Gypsy, Roma, and Traveller (GRT) population in the United Kingdom. Although the GRT population consists of three distinct ethnic groups, the United Kingdom Government has classified them as one ethnic minority (UK Government, 2022). The National Health Service (NHS) provides free healthcare in the United Kingdom. Despite this, GRT women engage less frequently with maternity services and experience higher rates of preterm birth and infant mortality than non-GRT women in the United Kingdom (Ekezie et al., 2024). In addition to these adverse health outcomes, members of the GRT population have reported racism, exclusion from public services, and a lack of cultural understanding from healthcare professionals (Claisse et al., 2024). Recent public health literature has emphasized the role of socioeconomic and structural barriers in limiting healthcare engagement for GRT communities (Chinoporou et al., 2025; Condon et al., 2019). However, researchers have paid comparatively little attention to the issue from a cultural perspective, particularly through the direct voices of GRT women. This study addressed a critical gap in the literature and may support the development of culturally responsive healthcare practices by focusing on GRT women's maternal health experiences and their perspectives on how their culture is reflected or excluded in their maternal care.

In this chapter, I introduce the study and provide essential background to interpret the health disparities affecting GRT women in the United Kingdom, as well as the

knowledge gap this research aims to address. I present the problem statement, outline the purpose of the study, and introduce the research questions that guide the inquiry. I also examine the study's significance within the broader public health field. The chapter concludes with an overview of the study's structure, including the conceptual framework, the nature of the research, definitions of key terms, and a discussion of assumptions, scope and delimitations, and limitations, along with a summary that transitions into Chapter 2.

Background

Recently, researchers have increased their efforts in examining the disparities faced by the GRT population in the United Kingdom, including within the specific area of maternal health. Poor service utilization among GRT women has been consistently linked to suboptimal maternal and neonatal outcomes (Condon et al., 2019; Ekezie et al., 2024). Institutional disadvantages such as temporary housing, limited formal education, and digital exclusion due to socioeconomic marginalization are key factors to poor overall health in GRT communities (Condon et al., 2019; Ekezie et al., 2024). Recent studies highlight the belief that a contributing factor for health disparities within the population lies in the disconnect between GRT culture and formal institutional pathways for healthcare and social services (Claisse et al., 2024; Dunn et al., 2024). Outcomes of this disconnect can present as a lack of cultural awareness among healthcare professionals. Lack of awareness is often seen as a limited understanding of GRT privacy preferences, gender-specific roles in the home and society, and culture-based health

remedies (Lehane et al., 2023). When researchers consider the intricacies of culture, the drivers of health disparities among GRT communities become clearer.

Despite this clarity, a significant gap in the literature remains. Previously, studies about maternal health from GRT came from the viewpoint of institutional bodies and healthcare providers. While these viewpoints are important in developing holistic care models, they do not represent the lived experiences of the GRT population (Dalmaijer et al., 2025). It is only through the population themselves that healthcare workers can learn about the social and cultural structure of the family unit and how this impacts health decisions and utilization, meaningful traditions, and understanding what maternal health means to the GRT woman. These first-hand insights are essential for developing effective and respectful interventions.

In this study, a culture-based framework was applied to explore why GRT women do or do not engage with healthcare professionals, focusing specifically on cultural context. Interview questions designed to elicit the values and traditions that matter most to GRT women during pregnancy and birth were used to investigate the intersection of cultural identity and health through cultural care theory (CCT). This theory has successfully guided healthcare interventions for ethnic minority populations in other countries (Nascimento et al., 2020; Zarth et al., 2024), though it had not yet been applied to the GRT population. The application of this framework in the study supported a deep understanding of the impact of culture on GRT maternal health and, when aligned with the principles of CCT, provided a map for creating a culture-based care model.

Problem Statement

The GRT population has disproportionately poor maternal care, which negatively affects the health of their newborns. Compared to the non-GRT population in the United Kingdom, GRT women attend fewer prenatal care appointments, and their infants are more likely to be born preterm, experience intrauterine growth restriction, and present with higher rates of congenital abnormalities (Ekezie et al., 2024). Recent research indicates that low socioeconomic status and a transient lifestyle contribute to suboptimal adherence to maternal health protocols within this population (Ekezie et al., 2023). However, researchers have yet to examine how these factors influence adherence to care or to analyze this health disparity through a cultural lens specific to the GRT population.

The need to explore this phenomenon from a cultural perspective was imperative due to the documented lack of cultural competence and culturally rooted protocols within the United Kingdom healthcare system. Current health models and maternal care protocols often don't acknowledge the cultural needs and health perceptions of GRT communities (Condon et al., 2019). Furthermore, a noted lack of cultural competency training for healthcare workers has contributed to the disconnect between the GRT population and the healthcare system (Condon et al., 2019). Thus, the problem addressed in this study was the lack of recognition and adaptation of cultural traditions in public health practices for the GRT population in maternal care, contributing to poor health outcomes, inconsistent care, and dissatisfaction with maternal care services. This research investigated cultural perceptions and developed a culturally tailored clinical care model.

The Purpose of the Study

This qualitative research explored the perceptions and experiences of maternal care among women in the United Kingdom GRT population. Interviews examined how maternal care is experienced from a cultural perspective by women who self-identify as GRT, are over the age of 18, and have given birth at least once in the past 3 years. For this study, the definition of GRT was the same as that of the United Kingdom government. Information was gathered from GRT women through interviews to understand how cultural practices and beliefs shaped the interactions and perceptions that influence maternal health. In addition, examination of these data identified culturally grounded definitions of health and clarified what constitutes meaningful maternal care within this population. I used Dr. Madeleine Leininger's CCT as the conceptual framework to guide this exploration of the connection between health and culture.

Research Questions

Research Question 1 (RQ1): How do women who self-identify as GRT who live in the United Kingdom and have given birth at least once in the past 3 years describe their lived experiences with maternal care received from the National Health Service within the context of their cultural beliefs and practices?

Research Question 2 (RQ2): How do women who self-identify as GRT and live in the United Kingdom who have given birth at least once in the past 3 years define maternal health and how is the definition influenced by cultural identity?

Theoretical Framework for the Study

This study is grounded in the Cultural Care Theory (CCT). The CCT, developed by Madeleine Leininger and outlined in a 1991 publication, emphasizes the integration of cultural beliefs and practices into healthcare to achieve outcomes optimal for the population and the health services (McFarland & Wehbe-Alamah, 2019). The logical connections between the framework presented and the nature of the study include understanding health phenomena through participants' cultural perspectives. I used the framework to shape the development of interview questions and data analysis to reflect the experiences of GRT women in the United Kingdom. I used CCT to address the research questions, specifically the concepts of accommodation/negotiation and preservation/maintenance. For RQ1, which examines how GRT women describe their lived experiences of maternal care within their cultural beliefs and practices, the concept of accommodation/negotiation is critical. The emphasis of this concept is on adaptation and collaboration between healthcare providers and individuals to align care practices with cultural values. By examining the extent to which GRT women perceive that healthcare providers accommodate or negotiate cultural practices, I identified barriers and facilitators to culturally sensitive maternal care.

RQ2, I examined how GRT women define maternal health and how cultural identity influences this definition. The concept of preservation/maintenance is directly applicable. The emphasis of this concept is on supporting and maintaining beneficial cultural traditions and practices within healthcare. Traditional practices that can be preserved and incorporated into clinical care became evident through examination of how

GRT women's cultural identity shaped their understanding and personal definition of maternal health. These concepts form a framework for answering the research questions and ensure the alignment of study outcomes with the development of a culturally congruent maternal healthcare model that meets the unique needs of the GRT population.

Nature of the Study

To address the research questions in this qualitative study, I used a focused ethnographic approach (Gertner et al., 2021) and conducted interviews with women who self-identify as GRT, live in the United Kingdom, and have given birth at least once in the past 3 years. This approach supported an in-depth exploration of the core concepts of maternal care from a cultural lens. Gertner et al. (2021) recommend a reflective process to deduce contextual factors, with further analysis of these factors used to identify the cultural definition of health as defined by CCT (McFarland & Wehbe-Alamah, 2019). Analysis methods were based on Saldaña's thematic analysis method.

To implement the research design, I recruited women who self-identify as GRT, live in the United Kingdom, are over 18, and have given birth at least once in the past 3 years. I developed an interview protocol to answer the research questions and asked charity groups working with the United Kingdom population to support recruitment. In addition, social media was used to reach women who identify as GRT and who do not engage with charity groups. I collected data through responses to interview questions from participating women. These responses reflected experiences with maternal health services in the United Kingdom and culturally defined understandings of maternal health within this population.

Definitions

Definitions of key terms used in this research:

Cultural competence: Having knowledge of other cultures, being self-aware of one's own cultural bias, and the ability to balance the two (Agner, 2020).

Maternal healthcare: The health of a woman throughout pregnancy, during childbirth, and the immediate postpartum period (Hamal et al., 2020).

Nomadic: A group of people leading a non-sedentary life whose movement is an important part of their identity (Heiskanen et al., 2024).

Socialized healthcare: Healthcare funded by the government that is offered at low or no cost to all legal residents (The Commonwealth Fund, 2025).

United Kingdom: Common term for the United Kingdom of Great Britain and Northern Ireland; comprises the countries of England, Scotland, Wales, and Northern Ireland as sovereign nations under a central government (UK Gov, 2024).

Assumptions

In this qualitative study, I used interview responses as data. Therefore, the primary assumption was that participants provided truthful responses. Specifically, I assumed that participants self-identify as GRT, have given birth at least once in the past 3 years, indicating recent healthcare experiences, and did so in the United Kingdom. To understand the impact of culture, I assumed that participants provided honest responses about their experiences and perceptions related to the cultural beliefs and practices of the GRT population. These assumptions form the foundation of the inclusion criteria.

Scope and Delimitations

The focus for this study was solely on GRT women in the United Kingdom over 18 who have given birth at least once in the last 3 years. The parameters set on participation criteria were deliberate and were in response to the identified gap in the literature regarding a cultural-based understanding of maternal care within the GRT population (Dalmaijer et al., 2025; Ekezie et al., 2024). Participants have been limited to those above 18 for ethical considerations. The specific ethical considerations include the power imbalances between an adult and minor and importantly, the inability to provide psychological safety for a minor (Montreuil et al., 2021). Those who participated must have resided in the United Kingdom while receiving maternal care so that the same specific healthcare system is analyzed. The time limit from giving birth to the interview is restricted to 3 years to capture the current methods and protocols of the NHS.

The theoretical framework for this study was the CCT, and the emphasis on the intersection of culture and health was paramount to the collection and analysis of the data. CCT was the best choice for this work due to the emphasis on culture within the theory and the role of cultural beliefs in shaping and experiencing health and healthcare (McFarland & Wehbe-Alamah, 2019). While the framework of intersectionality could be applied to the study, its focus would have been on broader health disparities rather than the impact of culture (Holman et al., 2021). Due to the specific nature of the study, which is bound by geography and ethnicity, the findings of this study are not widely transferable. The outcome could be used within other health and social care settings within the United Kingdom as some insights would be applicable. However, the study's

significant transferable aspect is the methodology that can be applied to other marginalized populations for specific health concerns globally.

Limitations

The primary challenge in conducting this study was recruiting participants from a transient population. Additionally, given the documented history of racism experienced by the population under study, there was hesitancy to engage with me as a researcher from outside their cultural background (Condon et al., 2019). A notable limitation was the limited allowable time period. The three-year time limit was necessary to reflect the current policy and protocols of the NHS and reduce memory bias. The age range of participants was an important limitation. Within the GRT population, marriage and, therefore, motherhood under the age of 18 is a cultural norm (Millan & Smith, 2019). Including mothers under 18 would require parental or guardian permission, which may have deterred some participants. This resulted in a lack of participants under the age of 18 who could have provided valuable context for the role that GRT culture has on adolescent mothers. Many GRTs struggle with literacy (Dunn et al., 2024), meaning that only those who can read or have the recruitment fliers read to them were likely to have participated.

Significance

This study was significant because it expanded upon previous research by delving deeper into identified barriers and explored their underlying reasons through a cultural lens that considered how the GRT population living in the United Kingdom defines maternal health. I aimed to create new insights into the underlying causes of barriers to care and to inform healthcare professionals on how to engage with the GRT population in

a culturally sensitive manner. Using the findings, I developed a cultural care model to assist clinicians in understanding and meeting the specific needs of this population.

The goal of this research was to improve maternal health outcomes and healthcare experiences for the GRT population. The driving force was to inform meaningful changes in current healthcare practices and protocols to make them more culturally sensitive and aware of the specific needs of GRT women. By delving into how this population perceives maternal health through their interactions with healthcare services and by establishing a care model relevant to their health and cultural needs, the research results serve as a catalyst for change.

CCT integrates elements such as the cultural environment, family structure, and individual beliefs. Creating a new model and implementing it in the United Kingdom could improve maternal healthcare by providing healthcare professionals with a framework for delivering culturally tailored care that could reduce poor maternal and neonatal outcomes. As well, addressing the stigma often associated with interactions between the population and healthcare providers supports positive social change. Fostering trust between the population and healthcare professionals improves public service experiences and helps mitigate existing inequities.

Summary

This chapter outlined the research problem by describing the health disparities affecting GRT women in the United Kingdom during pregnancy. The need to address this problem was supported through the study's purpose, research questions, and the importance of using CCT as a theoretical framework. A list of definitions provided

clarification of key terms. The significance of the study emphasized the impact on awareness of cultural-based healthcare.

The next chapter will include a thorough review of the literature on health outcomes, healthcare access, and the systemic challenges for the GRT population. Examination of existing research will address cultural competence, maternal healthcare disparities, and social determinants of health. This review will provide a foundation for understanding how this study will add to and expand upon the current body of knowledge on the subject.

Chapter 2: Literature Review

Introduction

The purpose of this qualitative study was to explore the perceptions and experiences with maternal care in the GRT population in the United Kingdom. Focusing only on women who self-identify as GRT and have given birth at least once in the past 3 years, I used individual interviews to capture insights rooted in recent experiences with health services. GRT women are adversely affected by maternal health disparities, including higher than average rates of preterm birth, labor-related complications, and maternal and infant mortality (Suffolk County Council, 2023; UK Parliament, 2019). One in five GRT mothers experiences the loss of a child, compared to only one in 100 among non-GRT mothers (UK Parliament, 2019). Beliefs and practices that are rooted in culture are theorized to shape these outcomes. Many GRT women have limited engagement with the healthcare system, voice a longstanding mistrust toward healthcare professionals, and experience systemic barriers related to their minority status. (Claisse et al., 2024; Ekezie et al., 2024). Although researchers acknowledge that culture influences health outcomes, researchers rarely examines how cultural factors shape health. No studies I found currently explore the concept of health from the cultural perspective of the GRT population.

Chapter 2 presents the strategy used to conduct the literature review. The review includes relevant peer-reviewed sources and seminal works selected for their usefulness to the topic. In this chapter, the theoretical framework used in this study is examined, including its core components, application in previous studies, and relevance to the

current study. The themes include maternal health inequalities, background and health of the GRT population, key barriers to maternal health access for GRT women, existing interventions and frameworks for maternal health, and identified gaps in the literature.

Literature Search Strategy

Conducting the literature review to identify peer-reviewed journal articles involved using several databases. The search strategy prioritized articles published between 2020 and 2025. However, because of the scarcity of literature on this topic, I expanded the criteria to include seminal works and peer-reviewed sources published near the cut-off period that offered essential insights unavailable in more recent publications. The databases searched included Science Direct, EBSCO, CINAHL Plus with Full Text, MEDLINE with Full Text, Scopus, and Directory of Open Access Journals. The keywords utilized to search the databases included: *Gypsy or Gypsies, Roma or Romani, Traveller, GRT, maternal health, prenatal health, pregnancy, antenatal, health engagement, culture, United Kingdom, health barriers, and social determinants of health*. Each term was searched in each database due to the limited number of sources and the desire to ensure a thorough search. By including a foundational knowledge of GRT health and culture worldwide, I was able to provide a holistic understanding of the culture and health barriers of the population, putting the specific barriers that the population faces in the United Kingdom in context. Researchers use literature reviews to identify existing sources, synthesize information, and make connections in the data that were not previously made, and to identify gaps in the literature that can be addressed.

Maternal Health and Inequalities

United Kingdom Maternal Health Trends

The United Kingdom is a developed nation which has a socialized healthcare service. As a high-income nation, the United Kingdom boasts a relatively low maternal mortality ratio (MMR) of 17 deaths per 100,000 live births, indicative of a generally healthy maternal population (Ward et al., 2023). The NHS in the United Kingdom achieves moderately favorable health outcomes by providing free access to socialized health services, having a highly skilled workforce, offering routine prenatal and postnatal care, and maintaining a well-established national referral system (NHS, n.d.). Despite the strengths of the NHS, maternal health disparities continue to exist in the United Kingdom, which disproportionately affect specific populations and stall advancements in maternal care. Black women and women living in the areas of highest deprivation in the United Kingdom have statistically significant higher maternal mortality rates than the rest of the United Kingdom population (MBRRACE-UK, 2024). These disparities are consistent with a modern socialized healthcare system that is not sufficient in mitigating barriers to health for minority and marginalized populations. The differences in health outcomes are therefore not a matter of access but embedded in the broader aspects of structural and societal barriers.

Maternal mortality often originates from limited healthcare encounters, health disparities, and poor engagement with marginalized populations. In an effort to understand these challenges, the United Kingdom government conducts a national maternal health review through a report called “Mothers and Babies: Reducing Risk

through Audits and Confidential Enquiries in the UK" (MBRRACE-UK). The 2019 MBRRACE-UK report revealed a lack of progress in reducing maternal mortality, with no significant decline since 2010 (MacGregor et al., 2022). Notable factors influencing the maternal mortality rate in the United Kingdom, according to the study, include cardiovascular disease and neurological conditions, with suicide leading to postpartum maternal death up to one year following the birth (MacGregor et al., 2022). Not all residents of the United Kingdom are equally at risk for poor maternal health or even death. Being from an ethnic minority background is correlated with a maternal death rate two to four times higher than white women, while women over 40 face a maternal mortality rate four times higher than those aged 20-24 (MacGregor et al., 2022). While ethnicity and age cannot be modified, the MBRRACE-UK report highlights the inadequacies in anticipating the needs of the highlighted populations.

MacGregor et al. (2022) highlighted risk factors such as age and race, separate from biological data, that impact maternal health. Socioeconomic deprivation is the chief risk factor for poor maternal and neonatal health as well as maternal death. Low socioeconomic status is often generational, impacting a succession of generations and compounding the impact of social determinants of health (SDoH) (Crear-Perry et al., 2021). MBRRACE-UK singled out teenage pregnancy, adverse life events, adverse childhood events, and being a victim of or in proximity to domestic or sexual abuse as factors linked to socioeconomic deprivation, which increases vulnerability and negatively affects maternal health (MacGregor et al., 2022). These pre-existing challenges

emphasize the need for proactive identification and targeted support within the healthcare system to mitigate risks before, during, and after pregnancy.

The NHS is currently not meeting the need for specific and targeted reporting to highlight individuals at risk, thus harming maternal health. Although the NHS is a national service, it lacks standardized guidelines for maternal health services, leading to regional variations in quality and in services offered. Workforce shortages and uneven resource distribution worsen disparities (OECD, 2019). Individuals in lower-income areas often cannot relocate for improved health services, creating further regional disparities. In those lower-income areas with high residency levels of marginalized populations, officials have noted a lack of formalized strategies to identify those most in need (Diguisto et al., 2022). Data gaps occur without strategies to identify and support high-risk populations, leaving surveillance and intervention efforts lacking (Diguisto et al., 2022; Ward et al., 2023). Systemic shortcomings within the NHS make it challenging to model maternal health trends due to a lack of standardized reporting, a necessary component for creating and implementing relevant interventions. Addressing these structural limitations is essential to reducing disparities and improving mothers' and their children's health and well-being.

Maternal Health in Minority and Marginalized Populations

Understanding the current state of maternal care outcomes is vital. Neglecting interventions could exacerbate or deteriorate outcomes, especially among populations already vulnerable to insufficient maternal care. Ethnic minorities encounter difficulties obtaining healthcare and receiving services catering to their specific needs. These issues

routinely originate from socioeconomic, cultural, geographic, and systemic factors. Minority populations routinely face substantial obstacles to achieving fair maternal healthcare outcomes, notwithstanding of their home country's location or economic status.

Geographic location functions as a barrier to care for many ethnic minorities who find themselves living in geographic locations that hinder their access to quality care. China's Enshi Prefecture, a rural location predominantly populated by Indo-Chinese ethnic minorities, experiences a higher than average maternal morbidity rate that is made worse by limited infrastructure, poverty, and limited healthcare delivery (Zhang & Lu, 2023). This is a pattern seen across Asia, particularly in the Southeast, where ethnic minorities most often live in rural areas and face economic and transportation barriers, as well as engaging in traditional cultural practices such as using non-medical home birth attendants (Herwansyah et al., 2022). The rural-urban divide intensifies health disparities, disproportionately impacting minority populations.

Across Europe, many migrants encounter difficulties in accessing maternal healthcare systems, similar to the challenges faced by ethnic minorities. Migrants frequently belong to minority groups within their host nations. Cultural traditions that set them apart from the wider population worsen these issues, resulting in significant health inequalities. Language differences, insufficient cultural competence in the healthcare system, and instances of discrimination, whether personally encountered or learning of, discourage women from pursuing prenatal care, leading to adverse maternal health outcomes (Fair et al., 2020). The cultural disconnect between minority populations and

the majority population's norms hinders healthcare service utilization and perpetuates distrust within minority communities (Herwansyah et al., 2022; Myatra et al., 2021). The relationship between culture and health becomes apparent when researchers investigate the root causes of poor health outcomes.

Poor health outcomes and experiences of discrimination extend beyond migrants and populations in developing and low-income countries. In the United States, Black and Latina women report higher rates of poor communication from healthcare providers, discrimination, and traumatic birth experiences compared to White women (Wang et al., 2021). Like minority women in other countries, these groups in the United States encounter geographic barriers that restrict their access to healthcare providers. Insurance limitations or lack of coverage can restrict their options for healthcare facilities, often to those facilities with fewer than average resources, exacerbating disparities in maternal care (Wang et al., 2021). Analysis of this literature shows that the income level or medical advancement of a country has little impact on the systemic issues faced by minorities, including systemic racism, cultural misunderstandings, and poor maternal health outcomes.

The health inequities present in the United Kingdom disproportionately affect minorities and marginalized populations. The root causes of the inequities are widespread; however, several commonalities consistently hinder or prevent minority populations from accessing quality care. Chief among those barriers is bias and systemic discrimination. Minority populations frequently report experiencing racism and judgmental attitudes from healthcare professionals based on their race, culture, or religion

(Thomson et al., 2022). The type and quality of care can also be negatively affected by systemic discrimination when compared to White women. Black and Asian women in the United Kingdom report receiving pain management that was inadequate compared to their stated pain level and need, as well as feelings of being ignored by health professionals (Silverio et al., 2023). The experiences of facing discrimination and receiving care that are not compatible with expectations from the healthcare system designed to support and care for every population have only further contribute to exacerbated health inequities.

Timeliness in accessing and receiving care is crucial in maternal health. Minority populations in the United Kingdom frequently either delay seeking maternal care during the recommended timeframes, or when they do, do not receive it at the speed that their non-minority counterparts do (Thomson et al., 2022). The NHS recommends expectant mothers seek midwifery care within the first 12 weeks of pregnancy. However, on average, 25% of minorities do not achieve this target (Thomson et al., 2022). Geographic and logistical barriers are among the primary reasons for these delays. Residency in locations without a healthcare center nearby, therefore needing to depend on transportation, a lack of organized prenatal courses available locally, and any associated costs overwhelmingly impact minority women (Jones et al., 2022). This negative impact worsens when immigrants or asylum seekers from minority groups face language and cultural barriers, along with limited knowledge of the healthcare system (Jones et al., 2022). These collective barriers only widen the gap between populations regarding how they access and receive care.

The healthcare system often does not fully appreciate the difficulty of not speaking the majority language, being of a different religion, and having different health concepts and associated practices. The cultural and religious practices often cited as barriers or reasons for non-engagement include respecting the request for a female health practitioner, complying with personal dietary needs, and supporting the request and practice of buying the placenta after birth (Thomson et al., 2022). The inability or unwillingness to support these requests or preferences leads to mistrust and eventual disengagement with the healthcare system (Silverio et al., 2023). Not having trust carries significant consequences that impacts physical health and mental well-being. High rates of mental health disorders, including prenatal anxiety and postnatal depression, are suspected among minority populations; however, many reject the mainstream healthcare system in favor of family support and guidance to not feel further discriminated against and to instead take part in practices that align with their cultural norms (Jones et al., 2022; Thomson et al., 2022). A failure to recognize and address cultural differences worsens systemic inequalities that disproportionately affect minority populations seeking maternal care.

The inequalities and resulting outcomes that minority and marginalized populations face do not stem from a single characteristic or determinant. Intersectionality, as a concept, was developed to understand how various characteristics, SDoH, and systemic forces, such as racism and sexism, intersect and interact to create inequities. (Hoang & Wong, 2023; Holman et al., 2021). Bringing together the past and viewing populations holistically through an intersectional analysis reveals the complex web of

factors that shape health, well-being, and social justice outcomes. Researchers and practitioners now apply the resulting framework to all gender identities, races, and cultural backgrounds considered minorities or marginalized.

Socioeconomic status (SES) is a key factor influencing health outcomes in maternal health. SES is instrumental in determining how pregnant mothers access healthcare, understand and acquire proper nutrition, and their overall well-being (Holman et al., 2021). An individual with low SES typically has an income below the average and lacks the means to access care financially through health insurance or private care when the quality of their local health services might be of concern (Vohra-Gupta et al., 2022). These factors act as barriers to accessing care. When researchers examine low SES intersectionality lens, it reveals that it overwhelmingly affects single mothers from minority and marginalized populations most often when accessing care. (Vohra-Gupta et al., 2022). Social and economic systems are often the root cause of these women's challenges, creating a fragmented and unmanageable landscape of care that increases inequities.

Another critical dimension of intersectionality in maternal health is the role of culture in shaping barriers and inequities. Historic racism and miscarriages of justice, language barriers, and different beliefs and opinions about medical intervention compound the effects of SES to result in poor maternal health outcomes (Holman et al., 2021). Socialization within communities acutely demonstrates this within maternal health. Socializing with other mothers of their race bolsters the resilience of mothers of color (MOC). However, an intersectional-based analysis reveals that these interactions

can increase emotional and mental health challenges as the shared discussions can cause systemic inequities and historical injustices to resurface (McKinney & Meinersmann, 2022). Such is the need to fully understand the impact of intersectionality when circumstances that appear positive build upon historic wounds and systemic inequities to cause further problems that entrench the individual into a cycle of battling inequities.

Systemic flaws and historic racism often cause emotional distress experienced during MOC gatherings. Listening to another person's experiences can recall and intensify memories of one's own negative experiences. To mitigate such outcomes, it is important to critically address the systemic failures that come to light through an intersectional lens. Researchers have identified bias and structural racism as the causes of minority and marginalized populations' avoidance of seeking timely care, which results in poor outcomes. (Holman et al., 2021; McKinney & Meinersmann, 2022). By highlighting this root cause and understanding the individual impact of compounding factors, researchers using an intersectional framework move away from reductionist approaches to public health and advocates for timely, culturally responsive solutions which will be better suited to addressing the nuanced causes of intersectional inequities (Vohra-Gupta et al., 2022). Utilizing intersectional practices that genuinely reflect and respond to the lived experiences of marginalized communities paves the way for more equitable care.

The GRT Population: Background and Health Context

Historical and Sociocultural Background of the GRT Population

GRT is a commonly used term in the United Kingdom to describe a single ethnicity. However, the GRT population comprises three distinct ethnic groups: Romany

Gypsies, Irish Travellers, and Roma migrants (Taylor & Hinks, 2021). Romany Gypsies originate from northwestern India, where historical encounters with European populations influenced their cultural identity and nomadic traditions during the medieval period (Taylor & Hinks, 2021). A similarly nomadic group, Irish Travellers originate from Celtic populations in Ireland and Scotland. Though due to their historical isolation, they are genetically distinct from modern Irish populations (Taylor & Hinks, 2021). Roma migrants, while also historically nomadic, do not trace their lineage to the Indian subcontinent like the Romany Gypsies. Rather, they originate from the Baltic region and maintained a distinct cultural identity despite their geographic dispersal (Taylor & Hinks, 2021). Though each is genetically and historically unique, each group comprising the collective population has a history of nomadic lifestyles that have kept them isolated from the modern world.

Though the term GRT comprises distinct ethnic groups, people often view them as a singular population because of their similarities. The United Kingdom government takes this stance and, as such, legally recognizes GRT as a singular legal ethnicity (UK Government, 2022). During the 2011 census, those who self-identified as GRT accounted for 0.1% of the United Kingdom population, equaling 57,680 individuals (UK Government, 2022). However, the census recognizes that due to many members in the population's transient nature and a historic reluctance to identify as GRT, this likely does not accurately represent the population, with estimated totals ranging from 150,000 to 300,000 (UK Government, 2022). The inability to accurately identify the population indicates the systemic barriers and inequities that the population faces.

Historically, the key defining aspect of the collective GRT is their nomadic lifestyle. This lifestyle emerged due to a desire to keep their community and cultural past insular and for practical reasons, such as seasonal work, which was essential to their economic survival (Office for National Statistics, 2022). Legal restrictions on mobile and temporary housing have increased, causing a reduction in traditional nomadic movement (Office for National Statistics, 2022). Increasingly, GRT families are moving into permanent housing, though many retain their traditional culture by living in compound-style communities with extended family which affords them a sense of separation from the broader population (Office for National Statistics, 2022). Some GRT view settlement as an economic necessity, while others feel it causes a loss of cultural identity, and many feel both are true (Office for National Statistics, 2022). This shift in settlement represents the current reality for the GRT population, a necessity to navigate the modern economic and legal challenges while maintaining their traditions.

No matter where they reside, many in the GRT population still hold onto the community's views about education, employment, and family structure. The GRT population strongly ties its family structure to its predominantly Catholic or Orthodox religious beliefs and traditional gender roles (Taylor & Hinks, 2021). In this setting, the GRT population does not prioritize formal education, believing that family and other community members provide the essential knowledge needed to thrive (Townsend et al., 2020). Many GRT individuals deeply mistrust formal education due in part to historical discrimination and negative experiences within the school system (Townsend et al., 2020). Male children are expected to become financial providers and decision-makers for

their families, and as such, they typically leave school by age 14 (Townsend et al., 2020). Female children, expected to assume domestic responsibilities, often leave school as early as age eight (Townsend et al., 2020). As well, the historically nomadic nature of the population has made schooling difficult for government officials to enforce (Office for National Statistics, 2022). Restricting school attendance further separates the population from mainstream society.

Work is a cultural expectation that is highly respected despite a lack of education. Males often engage in manual, seasonal labor, usually paid in cash, which avoids government involvement and taxes, making it hard to understand their economic situation (Office for National Statistics, 2022). The shortage of formal education is associated with lower than national average literacy rates for both men and women and adds another barrier to employment options (Office for National Statistics, 2022). These factors create an environment of economic marginalization that restricts financial stability and social mobility for the GRT population.

Marriage for the population is a celebrated milestone, often bringing in the broader community from far away. Given the central role of family in GRT culture, marriage typically occurs at a young age, with most brides between 16 and 17 years old (Danvers & Hinton-Smith, 2024). Strong religious beliefs emphasize the importance of abstinence before marriage, leading to many in the population celebrating the birth of their first child within the first year of marriage, often while the mother is still in her teenage years (Danvers & Hinton-Smith, 2024). The deeply rooted cultural traditions of

work, marriage, and education continue to shape the educational and social trajectories of GRT youth.

Family and the wider community are a cornerstone of GRT's identity. As a nomadic population, extended family and multi-generational friends migrate together, forming an insular micro-society that offers the population most of what they need regarding support and social interactions (Townsend et al., 2020). As some in the population settle into permanent housing, the micro-society community remains, with several families and long-time friends settling on the same plot of land in modular housing (Townsend et al., 2020). This type of community gives the population a sense of cultural identity and economic support and reinforces the multi-generational hierarchy that has always been present in GRT traditions (Taylor & Hinks, 2021). This enduring social structure ensures the preservation of cultural traditions, strengthens communal bonds, and maintains a distinct GRT identity despite external societal changes.

The hierarchy of the GRT population elevates elders in the community. Older males dictate the course of family activity, such as movement, education, marriage, and settling disputes. (Taylor & Hinks, 2021). Most communities often have a trusted male elder who advises on health matters, though when it comes to a woman's health during pregnancy and her children's health, it is the female elders who hold the power (Taylor & Hinks, 2021). While traditional gendered hierarchies remain largely intact, younger GRT individuals are increasingly making independent choices, including pursuing further education, delaying marriage, and, for some women, choosing to enter the workforce (Office for National Statistics, 2022). Such changes could enhance relationships between

the GRT population and the wider United Kingdom society, where historical biases, discrimination, and negative perceptions have led to marginalization. However, the lasting effects these changing cultural norms will have on the unity and identity of the GRT community are still unclear.

Health Inequalities in the GRT population

The GRT communities in the United Kingdom experience significantly poorer health outcomes than other populations. Specifically, the Romany and Traveller population have life expectancies 10 to 25 years shorter than those not in the GRT population (Dunn et al., 2024; NHS Race and Health Observatory, 2023). The entirety of GRT people have documented significantly higher rates of long-term and repetitive acute illnesses, chronic health conditions, and diagnosed disabilities when compared to the non-GRT population (Dunn et al., 2024). For comparison, the overall physical health of a GRT individual in their 60s is similar to that of White British individuals who are in their 80s (Friends, Families & Travellers, 2022; NHS Race and Health Observatory, 2023), highlighting the alarming discrepancies in health between the GRT population and other populations in the United Kingdom.

The GRT population faces significant challenges not only in physical health but also in mental health, which has reached a crisis level. Across both sexes, suicide rates in the GRT population are concerning. The suicide rates, particularly among Traveller men and GRT women, are several times higher than that of non-GRT populations (NHS Race and Health Observatory, 2023). Economic uncertainty, poverty, social exclusion, high rates of adverse childhood experiences, and the long-lasting effects of intergenerational

trauma contribute to this disparity (Kothari et al., 2024). The high rates of illiteracy in the GRT population, extending to low rates of health literacy for at least one-third of the population, make managing chronic health conditions difficult and challenging to speak to a professional about their mental health (Dunn et al., 2024). Taken together, these factors create significant barriers to mental well-being within the GRT population, exacerbating existing health disparities and making it difficult for individuals to access the support they need.

Several barriers increase health disparities for the GRT population. Language barriers are often chief among these, be it from speaking a language other than English, as even some Irish Travellers speak an English/Gaelic mix, which hinders the ability to communicate effectively with healthcare professionals (Condon et al., 2019; Dunn et al., 2024). Many healthcare offices do not offer interpreters for the language needs of GRTs, resulting in family or community members acting as interpreters; therefore, misinterpretation or purposeful exclusion of information that does not align with the cultural standards can occur (Condon et al., 2019). These challenges contribute to ongoing miscommunication, limited access to appropriate care, and deepening health inequalities within the GRT population.

Experiencing discrimination and stigma in healthcare settings creates barriers to care for GRT individuals. These experiences were examined by Condon et al. (2019) and Friends, Families and Travellers (2022) used interviews with GRT individuals and practice reports to explain the professional bias and inadequate cultural competence. Due to this, many individuals avoid admitting their GRT identity during healthcare encounters

due to historically experiencing dismissive attitudes, stereotyping, or unequal treatment (Condon et al., 2019). The United Kingdom's publicly funded NHS leaves financially disadvantaged GRT individuals with few alternatives for unbiased care, further exacerbating their underrepresentation in health records and limiting the development of population-specific interventions (Condon et al., 2019). These systemic barriers not only perpetuate health disparities but also reinforce the cycle of exclusion that has long affected the GRT population within the healthcare system.

The cycle of exclusion has impacted how and when the GRT population seeks care. As a result of the barriers and perceived discrimination, the population often seeks medical attention only in emergencies, with prenatal care being a rare exception (Kothari et al., 2024). Delayed care worsens the effects of acute illness. It restricts timely, accurate follow-up, as such care requires registration with a local doctor, an action the transient GRT population rarely undertakes (Condon et al., 2019). These barriers limit healthcare engagement and contribute to persistent health disparities within the GRT population.

Maternal Health in the GRT Population

The maternal health of GRT women underscores the extent and complexity of the inequities faced by this population, particularly during a critical period when health is of utmost importance. Limited access to healthcare, systemic discrimination and bias, and adverse SDoH contribute to the poor maternal health outcomes of GRT women, which places them among the most disadvantaged populations in Europe (Claisse et al., 2024; Ekezie et al., 2024). GRT women in the United Kingdom experience higher rates of maternal morbidity and mortality, stillbirths, miscarriages, and maternal complications

compared to non-GRT women (Suffolk County Council, 2023). Among the external factors responsible for negatively impacting maternal health the most in this population are poverty, low literacy levels, and limited or inadequate engagement with the healthcare system (Friends, Families, & Travellers, 2022). These findings emphasize the significant influence of social and systemic factors on the maternal health outcomes of GRT women.

Of significant concern for maternal health, the consistency and quality of engagement between GRT women and healthcare services continue to raise concerns. Although GRT women are not explicitly discouraged from accessing maternal health services, their engagement with such care continues to fall below the national average. Lower engagement often occurs as missed appointments and delayed initiation of prenatal care (Ekezie et al., 2024). A lack of comprehensive prenatal care is associated with a heightened risk for pregnancy-related complications such as pre-eclampsia, postpartum hemorrhage, and gestational diabetes (O'Brien et al., 2022). Negative prior experiences, perceived discrimination, and factors associated with a transient lifestyle hinder GRT women's ability to attend appointments and establish a relationship with healthcare providers regularly.

Further complicating efforts to understand and address maternal health disparities within this population is the fact that gaps in demographic data and the provision of inaccurate personal information to healthcare professionals contribute to this issue. Analysis of available data shows infant mortality rates are significantly higher for GRT mothers, with one in five experiencing the loss of a child, compared to one in 100 for non-GRT mothers (UK Parliament, 2019). Reduced engagement with maternal healthcare

services is believed to increase the risk of infant mortality within the GRT population (O'Brien et al., 2022). These disparities in maternal healthcare utilization reflect a broader intersection of social, cultural, and systemic factors that shape health outcomes within this population.

Mental health remains a highly stigmatized topic across various cultures. In the GRT population it is rarely discussed or openly acknowledged (Claisse et al., 2024). Within this population, people often associate mental health concerns with negative social consequences and consider seeking professional healthcare support socially unacceptable. As a result, many individuals experience psychological distress in isolation (Claisse et al., 2024). GRT mothers have reported a fear of disclosing maternal mental health concerns due to the perceived risk of social services intervention, including potential child removal from the family home (Claisse et al., 2024). Peer support groups and culturally sensitive mental health interventions have produced positive outcomes. Yet, they are consistently underused by both healthcare professionals and the GRT population (Friends, Families, & Travellers, 2022). These existing challenges in maternal mental health within the GRT population highlight the broader difficulties of mental healthcare access and engagement.

Despite efforts to implement culturally sensitive mental health interventions, other health services continue to lack cultural sensitivity or provide resources tailored specifically to the needs of GRT mothers remain absent. Immigrants who are GRT report struggling to navigate the United Kingdom's healthcare system. The United Kingdom's healthcare system, the NHS, operates on a general practitioner model that requires the

first encounter to be a consultation followed by a referral, unlike systems in many other countries that allow direct access to specialists (Claisse et al., 2024). The difficulties in navigating the NHS landscape and the lack of support to do so pose a barrier to engagement. As well, low literacy levels hinder healthcare utilization by affecting how providers communicate information. When healthcare providers fail to present information in a culturally relevant manner, GRT women engage less with maternal healthcare services, increasing the risk of adverse pregnancy outcomes (Ekezie et al., 2024). Prenatal health information typically includes available services, free medications, screenings, and recommended lifestyle modifications (Ekezie et al., 2024). However, without an understanding of GRT cultural perspectives and relevant explanations of healthcare topics, engagement with maternal healthcare services remains underutilized and ineffective, exacerbating pregnancy-related risks (Ekezie et al., 2024). GRT mothers experience challenges in accessing and using maternal healthcare services. These findings indicate broader institutional shortcomings, including inadequate cultural coherence, poor health literacy, and difficulties with healthcare system navigation.

Lifestyle factors and limited engagement can result in poor maternal and neonatal outcomes in the GRT population. Compared to the non-GRT population, significant differences for GRT women include higher rates of preterm births, younger maternal age, elevated fertility rates, and increased complications due to lifestyle factors such as diabetes and high blood pressure (Ekezie et al., 2024). Poor maternal health outcomes often correlate with adverse neonatal outcomes, particularly within the first four weeks of life (Ekezie et al., 2024). GRT newborns face more significant risks than their non-GRT

counterparts for low birth weight, infant mortality, and developmental delays during childhood (Ekezie et al., 2024). These trends reflect broader disparities in maternal and infant health within the GRT population.

GRT culture has a notable influence on maternal health by the high fertility rate and the early age at which many GRT women experience their first pregnancy. Large families are typical within GRT communities, with childbearing often beginning shortly after marriage (Ekezie et al., 2024). In the United Kingdom, the average age of first pregnancy among non-GRT women is 30.7 years, for GRT women it is significantly lower at 17.3 years (Suffolk County Council, 2023). Early and repeated young age pregnancies are associated with increased pregnancy-related complications and higher infant mortality rates (Friends, Families, & Travellers, 2022). This pattern demonstrates how cultural traditions, and reproductive behaviors shape maternal and infant health outcomes within the GRT population.

Cultural beliefs and practices within the GRT population dictate what is accepted to be normal behavior, some of which may be considered health risks within non-GRT populations. Cleanliness holds a crucial place in GRT culture, with women traditionally responsible for daily household cleanliness (Friends, Families, & Travellers, 2022). However, for families residing in mobile or caravan-style homes, poor ventilation and exposure to toxic cleaning chemicals can create significant health hazards (Ekezie et al., 2024). Beyond household cleaning practices, common behaviors not viewed as a risk to GRT individuals include traveling without using seat belt and residing in unsecured mobile accommodations during periods of transience further elevate maternal health

risks. These lifestyle factors underscore the complex interplay between cultural traditions, environmental conditions, and maternal health outcomes within the GRT population.

Cultural standards not only affect prenatal health, they continue into the postnatal period impacting overall maternal and infant health outcomes. Breastfeeding stands as one of the most prominent of these culturally shaped practices. Breastfeeding is associated with a stronger immune system, enhanced neurological development, and improved overall well-being for newborns (Boja Herrero et al., 2022). Despite the known benefits, many GRT women are discouraged from breastfeeding due to cultural beliefs that it is inconvenient as it interferes with household duties, is unnecessary due to the availability of formula, and is a social taboo due to modesty concerns (Boja Herrero et al., 2022). In GRT culture, elder guidance dominates over professional advice, meaning any discouragement or lack of support from the community's elders creates personal barriers to adopting breastfeeding (Boja Herrero et al., 2022). Taken in context with low health literacy and limited engagement with healthcare services, GRT mothers frequently lack the tools needed to make informed decisions about breastfeeding.

The maternal health experiences of GRT women reflect a disassociation between cultural practices, systemic barriers, and social determinants, which directly impacts health outcomes. The disparities affecting maternal morbidity and mortality, infant health, and mental wellbeing show just how intricate and unique the challenges faced by this population are. Understanding how these influences work together and against each other produces much needed insight into the broader context of health inequities within

marginalized populations, emphasizing the importance of culturally informed perspectives in addressing maternal health disparities.

Key Barriers to Maternal Health Access for GRT Women

Cultural Barriers and Mistrust in Health Systems

Historical experiences and cultural beliefs have shaped the relationship between GRT communities and healthcare services, leading to bias and social exclusion. The nature of the NHS is one of universal and standardized policies and protocols, leaving many GRT women to rely on generational knowledge, community expectations, and cultural tradition to make healthcare decisions that are meaningful to them. Family and cultural traditions that emphasize self-reliance and informal health networks led by GRT elders significantly influence GRT women's healthcare experiences more than institutionalized healthcare services and interventions (Condon et al., 2021). This reliance on cultural and familial knowledge over formal medical guidance contributes to limited engagement with healthcare systems, reinforcing and widening existing health disparities.

Roles and expectations based on gender dynamics influence health decisions, with the family structure emphasizing traditional roles, family responsibilities, and a defined authority structure. Cultural expectations place the care and well-being of children, family, and home above the woman's health, delaying or preventing routine and acute care (Ellis et al., 2020). Male dominance heavily shapes the GRT population by creating an environment of authoritative leadership, creating barriers because women must secure spousal or head-of-family approval before accessing health services (Pavlikova et al., 2020). Female elders are sought and enlisted for maternal and child health needs and

support, yet they too, are shaped by the decisions and expectations of male community members (Pavlikova et al., 2020). Tradition, family dynamics, economic insecurity, and systemic marginalization work together to shape how engagement with maternal healthcare functions for the GRT individual. Furthermore, the communal structure of GRT life reinforces commonly held beliefs that foster mistrust of formal healthcare systems and often prioritizes traditional cultural practices over professional clinical care. A historical skepticism about formal healthcare, deepened by gendered decision making processes and socio-economic challenges, adds further barriers to engagement with maternity services and limits the potential for positive maternal health outcomes.

The collectivist nature of the family and community structure results in a healthcare decision-making process that prioritizes community and family needs while adhering to cultural expectations and deprioritizes individual needs. Individual needs are discussed and decided in a group setting, influenced by culture, family needs and expectations, and the input of elders (Condon et al., 2024). The reliance on tradition and recommendations of the community elders results in using traditional remedies often at odds with medical advice, thus creating resistance to interventions and methods that do not align with tradition (Condon et al., 2024). Because GRT women may perceive adherence to mainstream healthcare practices as disrespecting their population and culture, the divide between them and healthcare professionals widens.

The preference for traditional, community-based support and advice reinforces social cohesion. The strength of this cohesion creates challenges for an individual GRT woman to seek outside care or advice. The importance and reverence of the elder female

GRT, particularly grandmothers, in providing health advice and performing traditional culture-based healing is so great that many in the population place a higher significance on this than the advice of healthcare professionals (Ellis et al., 2020). The emotional and social support of GRT communities creates a strong bond while also perpetuating misconceptions about maternal health and reinforcing mistrust in the healthcare community (Sarafian et al., 2024). The pressure and expectations within the population to seek an elder's help and advice are so intense that there could be a fear of disappointing the entire community if not sought, nor is there often the understanding that they have a choice in the matter.

Culturally, privacy and modesty expectations present additional barriers to healthcare engagement, specifically maternal health. The strict cultural rules and expectations of the GRT community dictate that there is significant importance placed on female bodily privacy, which can result in unease and refusal during medical examinations (Pavlikova et al., 2020). Many GRT women state a preference for female healthcare professionals. However, staffing limitations often prevent healthcare providers from meeting these requests, resulting in some women to avoid seeking care altogether (Villani et al., 2021). Modesty concerns about bodily exposure hinder open discussions about maternal health, and can result in fewer prenatal screenings and consultations (Villani et al., 2021). These cultural expectations and beliefs shape how GRT women interact with healthcare services, and reinforce patterns of mistrust and continuing disengagement from formal care.

Many GRT women have fatalistic beliefs about health that complicate their relationship and engagement with healthcare institutions. The GRT population often views health outcomes, including pregnancy outcomes, as predetermined due to divine intervention and plans rather than as something that is preventable or results due to the influence of healthcare professionals (Condon et al., 2021). This fatalistic belief often leads the GRT individual to believe that professional healthcare is unnecessary due to and that cultural traditions and family knowledge serving are the primary sources of guidance. As a result, GRT women may delay seeking care until emergencies occur. The delayed action results in missed opportunities for early engagement, support, and intervention, particularly during the critical prenatal period.

The limited understanding of healthcare professionals about the GRT population, combined with the perception that the NHS does not adequately address GRT women's cultural and family-oriented needs, further deepens their reluctance to engage with formal healthcare services. Because the healthcare landscape does not align with the expectations and demands important to the GRT population, there are feelings of alienation and the belief that the care offered by the institutions is neither robust nor relevant (Sarafian et al., 2024). Establishing a relationship with healthcare professionals is complicated by the transient nature of the population and a lack of understanding of healthcare processes mandated by the NHS (Villani et al., 2021). The distance created by these barriers supports the historical belief of GRTs that institutionalized healthcare does not support their culture and needs (Villani et al., 2021). These factors collectively

reinforce the existing divide between GRT communities and institutional healthcare services, further complicating genuine engagement and trust.

Tradition, family structure, economic insecurity, and systemic exclusion come together to create an intersection that influences the experiences of GRT individuals in accessing and adhering to maternal healthcare, resulting in disparities in outcomes. The communal nature of the GRT community structure is vital for social and personal support, however it reinforces negative beliefs about healthcare, causing avoidance and poor adherence, with a preference for traditional cultural methods.

Structural and Systemic Barriers

Many of the barriers to maternal healthcare for the GRT population are intrinsic. Mistrust in healthcare institutions, gender-based decision-making hierarchies, and socio-economic instabilities exacerbate the barriers to maternal healthcare and positive outcomes for GRT women. The transient nature of the population and the belief of GRTs that institutionalized healthcare does not support their culture makes engagement challenging. GRT women report feeling alienated from the United Kingdom healthcare system and often opt for traditional care. These barriers stem from within the GRT population. However, not all the barriers are internal. Healthcare practitioners and a modern digital health system have a part in marginalizing the GRT population.

The foundation of the GRT population's historical mistrust of the healthcare system is often rooted in their initial contacts, their general practitioner (GP). Morgan and Belenky (2024) noted that many GPs they interviewed held stereotypical beliefs about the

GRT population, believing them to be purposefully obstinate and likely to abuse smoking and alcohol. These biases, combined with the GRT population's negative beliefs and opinions of the healthcare system, often lead to misunderstandings and missed chances for better health outcomes (Morgan & Belenky, 2024). The harmful attitudes that GRTs and the broad healthcare professional landscape hold against each other will remain unless effective interventions break this cycle.

One of the primary systemic barriers facing the GRT population within the healthcare system is the lack of cultural competence among providers. Researchers have found that a lack of awareness of GRT culture due to insufficient training for GPs is often responsible for developing negative perceptions of GRTs (Ekezie et al., 2024). Cultural competency training teaches individuals to be sensitive and inclusive to diverse communities, often emphasizing effective communication (Ekezie et al., 2024). Research highlighting a lack of cultural competence training is associated with viewing GRT women as non-compliant, uncooperative, or resistant to medical advice, which is associated with dismissive and biased treatment (Chinoporou et al., 2025). Practical cultural competency training would tackle barriers such as language and communication, cultural norms including modesty, and including family members in the decision-making process (Morgan & Belenky, 2024). The systemic barriers put in place by an untrained workforce sensitive to the needs of diverse cultures have resulted in failures by the healthcare system to address the needs of its population.

In addition to the cultural competence of GPs in the United Kingdom, the growing dependency on technology has created barriers to accessing and maintaining care for the

GRT population. Historically, all GP appointments in the United Kingdom were made by visiting the GP office for a same-day appointment or calling at opening times (Ekezie et al., 2024). This method created a backlog as scheduling ahead was discouraged, and long waiting times meant frustrated patients (Ekezie et al., 2024). Many GP offices have now adopted electronic systems to schedule appointments, share health-related documents and records, and host several health interventions digitally rather than face-to-face. The heavy reliance on technology presents another barrier for the GRT population, stemming from their socio-economic and literacy standings, making digital-based healthcare inaccessible for many (Ekezie et al., 2024). Ensuring easy-to-navigate and understandable methods of appointment-making and methods to meet health needs that are not digitally based would be inclusive of the GRT population.

Existing Interventions and Frameworks for Maternal Health

Public Health Initiatives

There is a notable lack of data and protocol for interventions that aim to improve maternal experiences and outcomes in the GRT population. Current interventions targeting GRT women are fragmented because they fail to address root causes, are inconsistently implemented, and often lack cultural specificity (Ekezie et al., 2024). Previous attempts at interventions and health improvement outreach programs specifically for the GRT population in the United Kingdom that focus on health education and mediation have not been successful due to their lack of sustainability and failure to acknowledge and address cultural needs (Ekezie et al., 2024). The failures of

interventions are associated with a lack of cultural sensitivity and incorporation of cultural needs.

However, successful interventions targeting other aspects of GRT health, or maternal health among comparably marginalized populations, can provide valuable insights. Khan et al. (2023) found that successful interventions in high-income countries focused on populations facing health inequities focused on midwifery-led care, interdisciplinary service coordination, and community centered approaches. In particular, home visits led by midwives, continuity in care plans and providers, and an emphasis on culturally sensitive care resulted in improved maternal and neonatal outcomes compared to similar populations who did not receive this level of care (Khan et al., 2023). This specific type of care would aid in reducing some of the known barriers to maternal care for the GRT population, as it would strive to address the historical mistrust held between healthcare providers and the GRT population and integrate culturally important practices into the health plan.

Community-based healthcare that is culturally sensitive and geographically embedded is often successfully implemented. The REPRESENT study found a strong preference among marginalized populations, including GRT, in the United Kingdom for healthcare that was peer-led and culturally informed outreach methods and interventions (Ekezie et al., 2023). The study's participants favored non-judgmental care, such as community pharmacist-led care in the United Kingdom, which has been noted as accessible and culturally sensitive (Ekezie et al., 2023). Though not explicitly focused on maternal health, the REPRESENT study echoes the barriers to engagement for maternal

health within the GRT population that have been previously identified and offers solutions beneficial to not only GRTs but other ethnic minorities in the United Kingdom.

GRT-specific interventions in the United Kingdom highlight the need for trust-based care rooted in culturally sensitive practices. Mytton et al. (2020) found that when focusing on immunization uptake in GRT children, mothers emphasized the need for flexible appointment scheduling, recognition of family structures permitting multiple attendees, and integrating the health, social services, and education support services. Having far-reaching and holistic community-based support that provides health appointments and other services that an individual might need could increase data collection and support culturally sensitive practices across sectors (Mytton et al., 2020). The GRT mothers in this study voiced support for the co-production of educational material about vaccination schedules and their importance (Mytton et al., 2020), suggesting the co-producing approach could also apply effectively to maternal health.

GRTs around the world face barriers like those in the United Kingdom. In Western Greece, the usefulness of culturally competent midwives and obstetricians is accepted and implemented (Chinoporou et al., 2025). Despite this, Roma women in this area still report communication barriers and distrust toward healthcare providers, factors that negatively impact maternal health outcomes (Chinoporou et al., 2025). This finding suggests that for the GRT population, merely being culturally competent is not sufficient for improved maternal health outcomes. In Indigenous Australian cultures and African American communities, the direct involvement of the population in coproducing services and education results in improvements when combined with culturally sensitive care

(Chinoporou et al., 2025). A multi-system approach that recognizes and utilizes the GRT population in its design is the most likely to succeed.

Indigenous Health Model

Although the individual groups that comprise the broader GRT population reside in many countries, their longstanding presence in the United Kingdom suggests that an Indigenous lens best captures their specific health needs. Heaslip et al. (2019) proposed recognizing the GRT population as Indigenous based on the hypothesis that positive health outcomes resulting from this would be similar to other indigenous-based health models. Historical marginalization deeply rooted cultural traditions tied to geographical locations, and widespread systemic discrimination are by the GRT population in the United Kingdom as well as other recognized Indigenous populations such as First Nations individuals in Canada and Aboriginal Australians (Heaslip et al., 2019). Historically, Indigenous public health frameworks have brought together health and public services to provide multidisciplinary care and support and use co-design to incorporate the population's culture, values, and language (Heaslip et al., 2019). Though recognized as an ethnic minority within the United Kingdom, the GRT population does not have formal recognition as an Indigenous group. However, the lessons learned from Indigenous health frameworks could prove helpful for future intervention and framework design.

Theoretical Framework

Despite literature addressing SDoH among the GRT population, literature explicitly defining health from the GRT perspective and identifying critical health-related

activities within this culture remains limited. The pursuit of understanding maternal health as defined by the GRT population led to the identification of CCT. This theory supports ethnographic exploration of maternal health through a structured framework, aiding in discovering meaningful concepts that are the bedrock of culturally congruent care. The core concepts of this framework were examined, which guided the development of interview questions and provided analytical context. Applying CCT provided information that could ultimately lead to creating a culturally specific care framework tailored to maternal health within the GRT population.

Cultural Care Theory

The culture of the GRT population influences personal choices, while systemic barriers impact the population's overall health. Given the connection between health and culture, the theoretical framework most applicable to this topic is the CCT. Dr. Madeline Leininger first developed the foundational concepts of the CCT in the 1950s. However, it was not until the 1991 publication of her book, "Culture Care Diversity and Universality: A Theory of Nursing" that the theory was first published (Leininger, 1991). Frequent collaborator Marilyn McFarland along with Hiba Wehbe-Alamah refined the CCT in 2014, notably by extending the Sunrise Enabler Model which provides professionals with a tool for assessing and investing the cultural influence on care, as well as the modes of action, or core concepts, of culturally congruent care (McFarland & Wehbe-Alamah, 2019). This dissertation uses the McFarland & Wehbe-Alamah version of CCT.

Recognizing the role that culture plays in the lives of GRT, CCT serves as a framework for understanding the intersection between health and culture. McFarland &

Wehbe-Alamah (2019) described the notion that culture and health are inextricably linked; thus, comprehending the health of individuals within a particular culture requires an understanding of that culture itself. The outcome of applying this theory is culturally congruent care, which aligns an individual's personal beliefs and practices with the healthcare they receive (McFarland & Wehbe-Alamah, 2019). CCT works on the belief that by receiving culturally congruent care, health outcomes are improved, and relationships between individuals and healthcare providers flourish (Salinda et al., 2021). Applying this theory can highlight the specific aspects of GRT culture often overlooked by the healthcare system and significantly contribute to barriers to health and engagement.

Initially developed as a nursing theory but now used in all aspects where health is a factor, the CCT applies to work addressing long-standing and emerging health concerns. CCT provides a framework for identifying cultural factors that impact health and guides researchers and health professionals in developing care models based on the theory (Salinda et al., 2021). The core concepts of CCT are divided into three sections: cultural preservation and maintenance, cultural accommodation and negotiation, and cultural repatterning and restructuring (Ares, 2021; McFarland & Wehbe-Alamah, 2019; Salinda et al., 2021). The concept of cultural preservation and maintenance states that healthcare professionals should acknowledge, support, and include cultural traditions in their care (McFarland & Wehbe-Alamah, 2019). In practice, the application of this concept is demonstrated by the conscious effort of healthcare professionals to actively work with individuals to respect and incorporate cultural beliefs and practices as

appropriate (McFarland & Wehbe-Alamah, 2019). The involvement of the wider family unit in hospital stays, including dietary choices, support during discussions about health, and even the timing of tests and procedures, increased patient satisfaction among the American Roma population (Ares, 2021). There are times when cultural preservation aligns with accepted care practices, such as kangaroo care, a practice of skin-to-skin contact between a newborn and a caregiver, a practice central to many cultures that is known to improve newborn health outcomes and strengthen family bonds (Nascimento et al., 2020). Employing CCT prompts discussions about cultural practices the healthcare provider can collaborate on and strive to preserve.

The second foundational concept of CCT that supports culturally congruent care is accommodation and negotiation. Cultural accommodation and negotiation involve healthcare professionals adapting their practices to suit the needs of the culture they are working with (McFarland & Wehbe-Alamah, 2019). Achieving culturally congruent care often means negotiation between the healthcare professional and the individual, trying to find common ground and recognizing where concessions can occur while still providing the highest quality of care (McFarland & Wehbe-Alamah, 2019). Healthcare professionals cared for American Roma patients by balancing professional policy with cultural needs by negotiating privacy requests and creating protocols with cultural sensitivity (Ares, 2021). Similarly, healthcare providers in a NICU in Brazil applied this aspect of CCT by accommodating Indigenous families' preferences, negotiating unrestricted family access, and actively involving family members in caregiving activities, resulting in decreased parental stress and shorter NICU stays compared to

situations lacking accommodation and negotiation (Nascimento et al., 2020). The culturally sensitive practices of accommodation and negotiation bring together individuals and professionals to improve health outcomes.

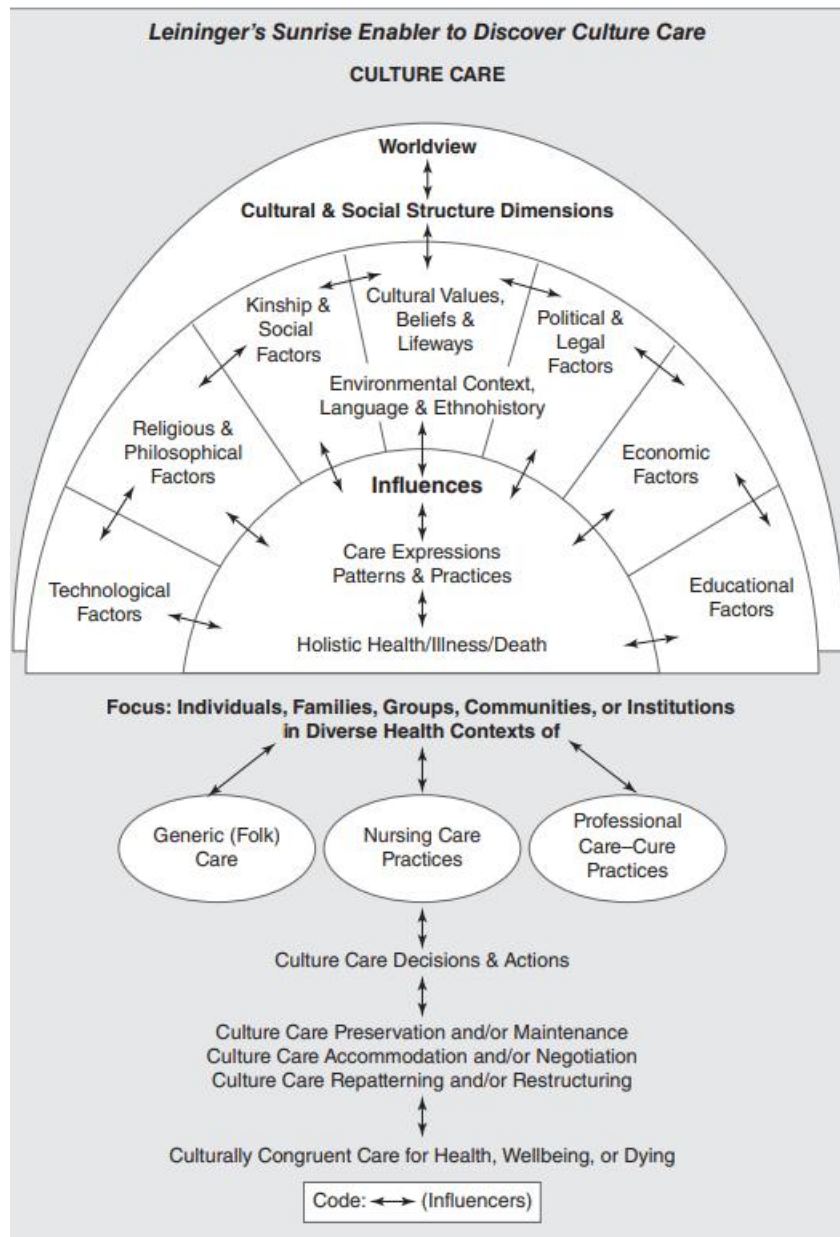
The third concept of CCT differs from the other two as it does not involve efforts to adhere to cultural norms or find compromises strictly. Instead, it looks to create new health behavior patterns. Cultural repatterning and restructuring maintain cultural sensitivity while actively engaging in interventions that seek to modify or replace harmful practices that may negatively impact on their health (McFarland & Wehbe-Alamah, 2019). Healthcare providers achieve the delicate balance between preserving culture and changing behavior through education and open dialogues, thus actively engaging participants in discussions and encouraging their willingness to change voluntarily (McFarland & Wehbe-Alamah, 2019). The success of repatterning and restructuring supports previous research, which states the willingness of those in the GRT population to collaborate on the coproduction of educational materials.

Leininger provided these concepts to facilitate understanding health through a cultural lens and to guide the identification of cultural factors that either serve as barriers or drive successful healthcare engagement. Leininger and McFarland (2006) developed the Sunrise Enabler Model (also known as the Sunshine Model), a visual framework aiding researchers and clinicians in gathering and applying cultural information. Further refined by McFarland and Wehbe-Alamah (2019), the model depicted in Figure 1 outlines specific factors that influence individuals' worldviews within a given culture. The Sunrise Enabler Model was built on an anthropological foundation that highlights the

connections between societal and environmental factors and culture (McFarland & Wehbe-Alamah, 2019). In systematically evaluating these factors, the model supports the development of a culturally congruent care model that meets the needs of individuals within their cultural context.

Figure 1

Sunrise Enabler Model



Note. From “Leininger’s Theory of Culture Care Diversity and Universality: an overview with a historical retrospective and a view toward the future,” by M. McFarland, and H. Wehbe-Alamah, 2019, *Journal of Transcultural Nursing*, 30(6), p. 540-557

<https://doi.org/10.1177/1043659619867134>). Reprinted by Permission of Sage

Publications

Use in Previous Studies

CCT has been used in the search for improved maternal care in studies by Ares (2021), Nascimento et al. (2020), and other studies seeking to explore the link between culture and healthcare. Zarth et al. (2024) used the theory to develop a care model for immigrant mothers in Brazil. Application of CCT highlighted systemic barriers including language, economic, and education, which impacted the maternal health experiences of the immigrant mothers (Zarth et al., 2024). The study took place during the COVID-19 pandemic, thus introducing barriers that are not typically present such as a reduced workforce and limited appointments, leading to fewer than average prenatal appointments for the mothers in the study (Zarth et al., 2024). Health seeking behaviors including prenatal appointments saw a reduction during the pandemic (Goyal & Selix, 2021). The CCT cannot determine if the culturally based response to barriers were impacted by the pandemic, however, it provided a framework for navigating the barriers regardless of their origin. This finding suggests that CCT is an appropriate theory to understand the intersection of barriers and culture-based healthcare.

It is not only immigrants or populations that are a minority in their country of residence that see benefits from applying the CCT. In Angola, the prevalence of traditional views on health and culture-based practices is high, creating a dilemma between the healthcare practitioners who wish to use modern medical methods and patients who value traditional methods (De Oliveira Tavares & Ramos, 2023). Angola is

one of the countries the United Nations targets to meet Sustainable Development Goals (SDG) as the child mortality rate is one of the highest in the world (UNICEF, 2023). The application of CCT in maternal and pediatric care settings to address the SDG goal of reducing the preventable deaths of newborns and children under five years old produced positive results from healthcare practitioners and patients, collaborating on negotiable actions and repatterning health behaviors (De Oliveira Tavares & Ramos, 2023). The use of the CCT in this study demonstrates the flexibility of the study when used to determine the majority population in a country. The study demonstrates the purposeful application of the theory to meet measurable goals and not merely increase engagement and patient satisfaction.

Application to Research Questions

CCT provides a structured framework for examining the influence of culture on health and supports researchers and healthcare professionals in developing culturally congruent care models. CCT informs the research process by guiding the development of research questions and interview questions that explore the experiences of GRT mothers living in the United Kingdom with maternal care. A culturally relevant definition of maternal health reflects the lived experiences, values, and practices described by participants from the GRT population. This definition served as the foundation for creating a clinical cultural care model using the Sunrise Enabler Model. The Sunrise Enabler Model is vital for exploring how culture shapes perceptions and actions related to healthcare. It enables researchers to examine technological, religious, kinship, political, economic, and educational influences on an individual's worldview and healthcare

preferences (McFarland & Wehbe-Alamah, 2019). In aligning cultural values with healthcare, CCT informs the building blocks for culturally congruent care that respects the needs of the population it serves.

Two core concepts of CCT, cultural preservation and maintenance and cultural accommodation and negotiation, will guide the analysis. Cultural preservation and maintenance will support identifying essential beliefs within GRT culture and assess whether healthcare professionals acknowledged values such as modesty. CCT provides a structured framework for examining the influence of culture on health and supports researchers and healthcare professionals in developing culturally congruent care models. CCT informs the research process by guiding the development of research questions and interview questions that explore the experiences of GRT mothers living in the United Kingdom with maternal care. The findings support creating a cultural definition of maternal health that reflects the lived experiences, values, beliefs, and practices of the GRT population. This definition will be the foundation for creating a cultural care model using the Sunrise Enabler Model. The Sunrise Enabler Model is a vital tool for exploring how culture influences perceptions and behaviors related to healthcare. It provides researchers with tools to examine technological, religious, kinship, political, economic, and educational influences on an individual's worldview and healthcare preferences (McFarland & Wehbe-Alamah, 2019). In aligning cultural values with healthcare, CCT informs the building blocks for culturally congruent care that respects the needs of the population it serves. This concept also reveals the origins of meaningful actions and beliefs surrounding health, helping define maternal health in a way rooted in GRT

cultural practices and traditions. Cultural accommodation and negotiation focus on interactions between GRT individuals and healthcare providers by identifying which aspects of healthcare can be negotiated and how cultural expectations can be worked into clinical care. Analyzing these interactions is crucial for understanding the relationship between cultural beliefs and health (Nascimento et al., 2020). This knowledge would prove vital in addressing the GRT population's historical mistrust of the healthcare system.

Identified Gaps in the Literature

Maternal health disparities are commonly researched, yet the literature rarely explores maternal health through a culturally specific lens, particularly in relation to GRT women. Studies focused on the GRT population often report maternal and newborn mortality rates and examine the social determinants of health that influence these outcomes; however, they rarely investigate culturally based understandings of health. Much of the existing research consists of quantitative studies that highlight disparities or qualitative work that explores GRT women's lived experiences without addressing how their cultural identity shapes these encounters. For example, Ekezie et al. (2024) identified structural barriers such as discrimination and digital exclusion, but they did not explore how GRT cultural customs and beliefs influenced women's experiences with the healthcare system. It is this absence of culturally grounded qualitative inquiry that leaves a critical gap in the literature. Without understanding how culture directly impacts maternal health experiences, healthcare professionals and policymakers risk providing care that fails to meet the specific needs of GRT women. To address maternal health

disparities effectively, research must incorporate cultural perspectives that reflect the lived realities and values of GRT communities.

In addition to the lack of culturally informed research, the literature reveals a gap in the application of theoretical frameworks, such as Leininger's CCT, in relation to GRT maternal health. Several sources stress the need for cultural competence in healthcare. Condon et al. (2019) and Families & Travellers (2022) emphasize that healthcare professionals must understand and respect cultural differences to build trust with GRT patients. However, Chinoporou et al. (2025) found that for Roma women in Greece, cultural competence alone lacked enough power to overcome the mistrust toward healthcare providers and therefore did not result in increased engagement with maternal care services. This demonstrates the limitations of cultural competence when applied without a deeper understanding of cultural values based on theory. CCT provides a structured approach to identify, maintain, and negotiate cultural practices in the healthcare setting. Applying CCT could help researchers discover how GRT women define maternal health thereby learning how care can be adapted to reflect those definitions. Using a culturally grounded theory such as CCT creates a path for mutual understanding between GRT women and healthcare providers, ultimately creating more meaningful engagement and improved maternal health outcomes.

Summary and Conclusions

The GRT population in the United Kingdom use their cultural beliefs as a guide for navigating life, including their health decisions. Research proves that in the United Kingdom, GRT women have higher rates of preterm birth, labor-related complications,

and maternal and infant mortality than non-GRT women (Suffolk County Council, 2023; UK Parliament, 2019). Beliefs and practices rooted in culture are believed to affect these outcomes, as many women engage less with the healthcare system, carry historical mistrust of healthcare professionals, and face stigma tied to their GRT status (Claisse et al., 2024; Ekezie et al., 2024). Longstanding inequities across systems like health and education fuel these health disparities, as these systems often disregard the cultural realities and needs of the populations they serve. These systems often disregard or fail to recognize the impact and importance of culture for the GRT, resulting in feelings of neglect and racism from within the population and hurting engagement, leading to health needs going unaddressed. Therefore, the population's poor health outcomes stem not solely from healthcare practices but from the intersection of systemic barriers and cultural needs that remain unmet.

Researchers have explored disparities in GRT maternal health to identify social determinants and health outcomes, but they have given limited attention to how culture impacts health. Existing research focuses on identifying systemic barriers, not how the influence of culture dictates interactions and perceptions of those systems (Ekezie et al., 2024). While the existing literature acknowledges poor engagement resulting from social determinants and barriers, they fail to address the personal perception of health practices and, therefore, the decision to engage from a culture-based worldview. The absence of holistic research grounded in a culture-based theory disconnects the motivations and reasoning behind GRT women's actions from the healthcare practices they encounter.

This study built upon existing literature by employing a theory that views culture as a central component to understanding health views and behaviors and provides a framework for using that culture-based knowledge to improve health outcomes. The CCT provides the foundation for exploring lived experiences to identify the cultural norms, historical practices, and family and societal structures that act as a cornerstone for health engagement and positive health outcomes (McFarland & Wehbe-Alamah, 2019). Studies that have used CCT to employ culture-based practices have demonstrated improved trust and health (Nascimento et al., 2020; Zarth et al., 2024). Applying CCT acknowledges that creating a culturally competent workforce alone does not improve the health of marginalized populations (Chinoporou et al., 2025); instead, healthcare must hold meaning within the cultural context of those it serves. By applying CCT, this study explored maternal health within a population not previously examined through this framework, eliciting culturally grounded definitions of health and identifying the fundamental needs of GRT women as they navigate the maternal healthcare system in the United Kingdom.

Understanding the lived experience of GRT mothers is best explored through an ethnographic approach. Ethnography is a research design that views the actions and interactions of individuals as a result of sociocultural dynamics (Dahal et al., 2024). Using interviews with a guide based on the core constructs of CCT, the ethnographic approach aided in revealing the cultural context in the participants' answers. This approach addressed the gaps in literature by uncovering how cultural beliefs and values

shape GRT mothers' perceptions of maternal health and their engagement with the healthcare system.

Chapter 3: Research Method

Introduction

In this chapter, I discuss the methodology used to explore the perceptions and experiences with maternal care in the GRT population in the United Kingdom. In this qualitative focused ethnographic study, I examined how cultural beliefs and traditions influence experiences with maternal healthcare services. Chapter 3 presents the research design and rationale, the role of the researcher, and the procedures for participant recruitment, data collection, and data analysis. It also outlines issues of trustworthiness and ethical considerations that guided the researcher during this study. These strategies are designed to align with the study's conceptual framework, CCT, and ensure that data collection and analysis meaningfully and truthfully reflect the experiences of the GRT women interviewed.

Research Design and Rationale

I chose qualitative research to answer the following research questions:

RQ1: How do women who self-identify as GRT who live in the United Kingdom and have given birth at least once in the past 3 years describe their experiences with maternal care received from the National Health Service within the context of their cultural beliefs and practices?

RQ2: How do women who self-identify as GRT and live in the United Kingdom who have given birth at least once in the past 3 years define maternal health and how is the definition influenced by cultural identity?

Qualitative research was the appropriate design for this type of study because it involved the use of interviews to collect data. In-depth interviews were necessary to answer research questions because they are based on personal experiences and perceptions. Researchers use qualitative research to investigate the causes of behavior while adding context directly from the participants (Lim, 2024). Participants provide context through open dialogues in focus groups or individual interviews (Lim, 2024). As the nature of the research questions were sensitive, personal interviews that allow for privacy were recommended (Silverio et al., 2023). The study used qualitative methods and open-ended questions to explore how participants described maternal care and culture.

A focused ethnographic approach was employed to explore the core concepts of maternal care from a cultural perspective. Traditional ethnographic research began with Lewis Henry Morgan and his study of the cultural and social workings of Native American populations and formalized by the cultural immersion fieldwork of Bronislaw Malinowski in the Trobriand Islands from 1914 to 1918 (Ugwu, 2017). Traditional ethnography has its roots in anthropology and sociology and emphasizes immersion into a cultural setting to study behaviors, values, and social interactions in their natural context (Jones & Smith, 2017). Ethnographers typically adopt participant observation, often complemented by interviews, to understand phenomena through first-hand community engagement. This immersion allows researchers to generate rich, in-depth data that reveals the complexities and shared meanings found in cultural groups. The role of the researcher extends beyond data collection, it is crucial for interpreting cultural

nuances, which require reflexivity and awareness of positionality (Jones & Smith, 2017). Ethnography is especially valuable in healthcare, providing detailed insights into service delivery, organizational culture, and patient experiences.

Focused ethnography offers a modern and time efficient alternative to traditional ethnography, providing researchers the ability to conduct shorter, targeted studies without exhaustive cultural immersion. Trundle and Phillips (2023) explained that this method supports brief yet rigorous engagement with specific populations or issues, making it ideal for applied research under practical constraints. Similarly, Black et al. (2021) described focused ethnography as a postmodern adaptation of traditional ethnography that uses interviews and observation to explore cultural practices in smaller-scale, context-specific ways. Both sources highlighted their suitability for health research and emphasis on adaptability and reflexivity over traditional ethnographic immersion.

Post-modern focused ethnography was best suited for this research study as it emphasizes subjective realities and values the personal perceptions provided by the participants (Ryan, 2017). Analysis based on this approach therefore accounts for the role of culture in shaping perceptions of healthcare and definitions of culturally relevant care among the GRT population and examines these themes through a cultural lens, a method often used to understand health inequities and social injustice among marginalized populations (Ryan, 2017). Although this study did not involve immersion fieldwork, the narrow focus on the subject matter and emphasis on culture-based perspectives made focused ethnography the most appropriate research approach.

Role of the Researcher

The role of the researcher is central to the process of using semistructured interviews in a qualitative study. I was an observer, engaging participants through the interview guide and prompting them to provide more detail to ensure the quality of the data given and observing their nonverbal behavior. In studies such as this, the researcher is able to prioritize the participants' experience and guarantee that external factors do not impact data collection by taking the position of an observer (Sutton & Austin, 2015). As an observer, I was able to preserve the authenticity of the data for analysis purposes while preserving the integrity of the participants' voices.

The characteristics of the population must be acknowledged and safeguarded. The GRT population should be treated with sensitivity, recognizing their marginalized status. Fletcher et al. (2019) emphasized the need for ethical engagement based on reflexive practices, cultural humility, and acceptance of realities as presented by the participants. Gertner et al. (2021) also called for reflexivity as this is essential for an ethical researcher positioned in ethnographic research to acknowledge and remove any personal bias. By approaching this research with cultural humility and reflexive practices, I worked within my role as a researcher in a respectful and non-biased manner.

Acknowledging where power imbalances may occur and mitigating them is essential to qualitative research, particularly in ethnography. As the researcher, I recognized that participants may view me as holding a position of power because of my academic background. Therefore, I took responsibility for actively balancing that power by centering the interview on the participant and their needs rather than my own.

Participants chose the interview location, public setting or online, and time of the interview, prioritizing their comfort and encouraging a sense of control over their narrative. All interviews began with acknowledging that some topics may be uncomfortable to discuss and clarifying that participants have the right to pause or end the conversation at any time. Providing participants with the power to determine their comfort level and the autonomy to engage or stop the interview is the basis of a balanced interview (Fletcher et al., 2019). By emphasizing personal autonomy, I actively worked throughout the interview to reduce power imbalances and ensure a safe, comfortable environment. Recognizing the value of the participant's time and contribution, as well as an effort to further reduce power imbalances, incentives were used to compensate them, along with offering a reimbursement for any travel costs.

I have no professional affiliation with the GRT population or any partner sites that I used to recruit participants. The lack of affiliation contributed to a balanced power dynamic, and ethical interviewing. I provided a financial incentive for participants to acknowledge their time and offset potential transportation costs. Providing incentives is encouraged when working with marginalized populations as an acknowledgment of the valuable data they are providing (Fletcher et al., 2019). The use of incentives and the interview protocol was provided to the Walden internal review board (IRB) for review, ensuring that the study meets all ethical requirements.

Methodology

Participant Selection Logic

Participants for this study were women aged 18 and older living in the United Kingdom who identify as GRT and had given birth at least once in the last 3 years. The logic behind this selection criteria was to ensure recent relevant experience with healthcare services. Recent experiences with the healthcare system produced outcomes that are representative of the current operational methods and standards, allowing for conclusions that reflect how the healthcare system can best meet the needs of the GRT population through a cultural care model. Additionally, the three-year time frame aimed to reduce the recall bias. Recall bias occurs when participants misremember events due to the time between the event and the interview and therefore report inaccuracies (Jager et al., 2020). The time window set at 3 years helped mitigate recall bias while remaining broad enough to increase the potential participant pool.

Instrumentation

The primary instrumentation of qualitative research is the researcher themselves. Yoon and Uliassi (2022) emphasized the importance of the researcher as an instrument due to their impact on every aspect of the study. The interconnectedness of the researcher and study requires the researcher to be in a continuous state of reflexivity, awareness of the impact of their own bias, and background on the collection and interpretation of data (Yoon & Uliassi, 2022). It is therefore important to view the researcher as an instrument who must be calibrated for bias mitigation.

The interview protocol (see Appendix C) was developed for the specific purpose of this research was the other instrument used in this research. The semistructured interview guide (see Appendix D) was designed to elicit answers that are rooted in culture-based experiences and perceptions of the participant. The questions are aligned to the core concepts of CCT, namely cultural preservation and maintenance, and cultural accommodation and negotiation. Additionally, the interview guide addresses each of the factors of the Sunrise Enabler Model. Collecting data on each Sunrise Enabler Model factor allowed for an ethnographic analysis and development of a GRT cultural care model for maternal health. See Appendix G for tables which show the alignment between research questions and CCT core concepts and Sunrise Enabler arms.

Procedures for Recruitment, Participation, and Data Collection

Recruitment for this study began with the establishment of a sampling strategy. I used purposeful sampling as the primary method, as it best supports research focused on a specific population. This approach enabled the recruitment of individuals uniquely positioned to provide insight into a phenomenon that others cannot (Palinkas et al., 2015). For this study, I recruited female members of the GRT population who are aged 18 and over and have given birth at least once in the last 3 years, as they alone can speak directly to the maternal health experiences under investigation.

I also implemented snowball sampling as a secondary strategy. Snowball sampling is a subtype of purposeful sampling in which study participants refers others from their community who meet the inclusion criteria (Palinkas et al., 2015). This method proves especially effective when working with marginalized populations, as it fosters

trust through community-based referrals (Palinkas et al., 2015). Snowball sampling allows the recruitment of participants who may not engage through initial recruitment channels.

Initial recruitment took place through social media and printed flyers posted in charity organizations that work with the GRT population. Social media is a widely used strategy to access historically underrepresented populations and offers a level of privacy often valued by participants (Matthes et al., 2024). I posted an image (see Appendix A) acting as a recruitment poster with a QR code linking to a Microsoft Form that is the study's consent form and my Walden University email address. I identified Facebook, Instagram, and TikTok groups for the GRT population. Recruitment posters (see Appendix B) with the same information as the social media posts, including QR code and email address, were placed in the offices of charity organizations that work directly with the population across the country. All images were created using free assets from canva.com.

The consent form includes a study overview and research questions, a privacy statement, a required confirmation of eligibility, and the ability to digitally confirm consent. Those who confirmed eligibility and provided preferences about interview location, online or in person, date, and time received an email that scheduled the interview. All online interviews were conducted via Zoom.

Each participant received their signed consent form which includes a privacy and data storage statement by email once they submitted the form and were instructed that they could contact me via email or phone to ask questions before the interview.

Confirmation emails were sent seven days and one day prior to the scheduled interview. Upon completion of the interview, participants were reminded of their rights and given an opportunity to ask any question. At this point, they were told that a transcript would be emailed to them and informed that I may contact them if clarity is needed on an answer, as well as their right to refuse any follow up procedures. All communication and data storage will be kept on my password-protected personal computer for 5 years, as required by Walden University.

At the beginning of each interview, participants were provided with an overview of the study, the purpose and potential outcomes of the study was explained, privacy protections were reiterated, and participants were reminded of their right to pause or withdraw at any time. All interviews were audio recorded, whether in person or online, without collecting identifiable information. Prior to beginning the interview, participants were asked if they consented to the interview being recorded. Audio recording supports semistructured interviews by allowing the researcher to note non-verbal communication and ask follow-up questions that enhance understanding of the topic (Rutakumwa et al., 2019). Only the participant's anonymous alpha-numerical ID was used during the interview and throughout the research process.

The target number of participants remained flexible, though an initial goal was fifteen. This number was supported by targets often used for ethnographic research of between six and fifteen participants (Dahal et al., 2024). Qualitative research aims to reach saturation, at which new interviews no longer produce new information. Thematic saturation occurs when no new themes emerge during analysis, and is typically reached

between twelve and twenty-four participants, depending on the topic's complexity (Vasileiou et al., 2018). Meaning saturation is a deeper level of analysis, reached when no new insights or conceptual details appear during analysis (Hennink et al., 2016). Since this study prioritized cultural depth over generalizability, recruitment relied on saturation and not a predetermined number as the guide for the final sample size.

Data Analysis Plan

Qualitative data analysis involves examining non-numerical data to derive meaning. In this study, qualitative data were obtained through semistructured interviews. Transcripts of participants' interviews were analyzed using Saldaña's thematic analysis method. This method follows a multi-step process that identifies unique topics by marking them with a word or short phrase summarizing the content (Saldaña, 2021). This process of descriptive coding constituted the first cycle of coding. After completing the first cycle, the second cycle of coding began.

The first step in the second cycle of coding involved reviewing the descriptive codes and grouping them into categories that represented similar concepts, those served as the categories (Saldaña, 2021). These categories were then organized into broader themes. The analysis of themes allowed for an in-depth understanding of recurring ideas and concepts within the data (Saldaña, 2021). The themes of the research questions concerning maternal healthcare experiences from a cultural perspective was the focus of the analysis. Thematic analysis aligned with the targeted focus of ethnographic research. This method uncovered specific concepts and events that influenced cultural perceptions and behaviors (Naeem et al., 2023). Exploring these themes within the CCT framework

was essential to addressing the research question of how the GRT population defines maternal health.

Data analysis occurred after uploading each interview into NVivo 15 using a student license for the software. NVivo, a qualitative data analysis software package, was installed on a password-protected personal computer. Each transcript was uploaded into NVivo. I began first cycle coding by highlighting relevant text and using the 'Add Node' feature (QSR International, n.d.). I recorded each node in the software, enabling the selection of existing codes or the creation of new ones. Second cycle coding involved reviewing and organizing all nodes into parent nodes representing categories. Themes were then assigned to each parent node, producing a visual map that will trace the analytical process from concept to category to theme. This process was repeated after each interview to monitor for data saturation. All data were coded and analyzed, including discrepant cases, for which there were no follow-up interviews.

Issues of Trustworthiness

Trustworthiness is a key component of qualitative research, ensuring that the study honestly captures participant's experiences truthfully and contributes meaningfully to the broader research community. Creating trustworthiness involves addressing the concepts of credibility, transferability, dependability, and confirmability. Credibility is often called the internal validity of research. It is defined as confidence in the authenticity and truthfulness of the data collected and the interpretation of that data (Elo et al., 2014). Credibility is achieved by using methods that help ensure the findings accurately reflect what participants shared and even quoting participants directly (Stenfors et al., 2020).

This study achieved credibility by using audio recordings during interviews, which relies on technology rather than memory to accurately recall the participant's answers and reduce the risk of transcription bias. A reflexive journal was also used throughout the analysis to document coding decisions and thought processes. This form of self-reflection helped to identify the instances where the researcher may have influenced interpretation, creating an opportunity to acknowledge and correct potential bias (Stenfors et al., 2020). Awareness of one's voice as a researcher is crucial to ensuring objectivity and accuracy.

Reflexivity also played an important role in supporting dependability and confirmability. Dependability is the consistency of the research process, specifically data, from start to finish (Ahmed, 2024). Dependability was reached by adhering to a coding guide that allows for each piece of data to be coded the same from participant to participant (Nowell et al., 2017). I achieved dependability by keeping a reflexive journal, allowing for the creation of an audit trail, making it possible to track how and why coding decisions were made and ensuring they remain consistent. Confirmability, which speaks to the researcher's objectivity, is defined as the ability of the same conclusion to be reached from data no matter who analyzes it (Elo et al., 2014). Confirmability can be ensured by processes that ground interpretations in participant data rather than the researcher's assumptions (Ahmed, 2024). I achieved confirmability by maintaining documentation of analytic decisions, which helps keep this process transparent. Transferability, the final element of trustworthiness, is how the study's findings may apply to other populations or settings (Stalmeijer et al., 2024). This is often addressed during participant selection, as the specifics of selection criteria dictate how generalizable

the outcome will be (Elo et al., 2014). The research in this dissertation focused on the views of the GRT population in the United Kingdom regarding maternal care within the NHS. While the findings are specific to this context, the ethnographic approach informed by CCT may be relevant to other culture-reliant populations in health research.

Ethical Procedures

As a student at Walden University, IRB approval must occur before recruiting participants. The approval process began once all required documentation were submitted and formally approved by the IRB. These documents were included in the dissertation for reference. Each potential participant was given a consent form that included a description of the study and a statement outlining their right to withdraw at any time and the researcher's contact information for any questions or concerns. These materials were made available through Microsoft Forms. Upon completing the consent form, participants received a copy of all documents listed in this section at the email address provided on their consent form. At that point, participants were assigned an anonymous alpha-numeric identification number to ensure their confidentiality throughout the study.

It is crucial to remember that the participants in this study come from a marginalized population and, therefore, must be treated with sensitivity and consideration for their position. When working with marginalized populations, it was important to provide autonomy to the participants by bringing them into the decision-making process (Adley et al., 2024), such as the time and location for the interview. Furthermore, this process helped to mitigate any power dynamics that participants may perceive. Participants may view the interviewer as authoritative or judgmental due to power

differentials, which can drastically affect the interaction. To remedy this, the researcher consistently used reflexivity and an interview approach that centered the participant's voice, encouraging open, uninterrupted expression (Adley et al., 2024).

Acknowledging the participant's time and contributions as valuable contributions is vital when working with individuals from economically disadvantaged or marginalized backgrounds. Compensating participants is a recommended ethical practice in such contexts (Adley et al., 2024). Therefore, each participant will receive an electronic Amazon voucher reflecting the time spent during the interview (approximately 60 minutes) and additional support for travel costs if applicable. The value of each voucher was £15, based on the current United Kingdom living wage guideline of £12.21 per hour (UK Gov, 2024), taking into account that the interview may run over an hour. Each participant received the same value regardless of time spent during the interview. Vouchers were sent to the email address provided during the consent process.

Summary

This chapter presented the research design and methodology for exploring cultural influences on maternal healthcare as experienced by GRT women in the United Kingdom. It outlined the focused ethnographic approach, participant selection through purposeful and snowball sampling, and data collection methods based on a researcher developed semistructured interview guide. This chapter also described the thematic analysis process that will be employed which is based on Saldaña's coding method and the use of NVivo software for data management. Ethical considerations and strategies to

establish credibility, dependability, and confirmability supported by a statement on transferability were also presented.

The next chapter, Chapter 4, will present the findings of the study as discovered during the thematic analysis. Included in the chapter will be an overview of participant demographics, a description of the interview setting, and the themes uncovered from the data analysis process.

Chapter 4: Results

Introduction

The purpose of this qualitative study was to explore the perceptions and experiences of maternal care in the GRT population in the United Kingdom. To address the noted lack of research for this population that accounts for their culture and the cultural impact on health, I used a focused ethnographic approach supported by the use of the CCT as the theoretical framework. The semistructured interview guide that I used in this study was developed for the purpose of answering the following research questions:

RQ1: How do women who self-identify as GRT who live in the United Kingdom and have given birth at least once in the past 3 years describe their lived experiences with maternal care received from the National Health Service within the context of their cultural beliefs and practices?

RQ2: How do women who self-identify as GRT and live in the United Kingdom who have given birth at least once in the past 3 years define maternal health and how is the definition influenced by cultural identity?

In this chapter, the setting of the study will be discussed in detail including recruitment, participant demographics, and the process of data collection. A thorough data analysis will be presented, detailing the coding process and identifying five different themes that emerged from analysis and how they answer the research questions. Finally, this chapter includes discussions about the efforts made to ensure trustworthiness throughout the study.

Study Setting

The initial recruitment plan involved using social media platforms, followed by partnering with volunteer organizations that work with the GRT community. GRT communities maintain a strong online presence on platforms such as TikTok; however, engagement through social media proved difficult. Several volunteer organizations agreed to display recruitment posters; however, these efforts did not lead to participant engagement.

The recruitment strategy then shifted to connecting with liaison groups funded by county councils whose role includes engaging with GRT communities and supporting access to services such as health, education, and social programs. Recruitment efforts were successful through one county liaison group, which resulted in all participants either residing within the same county and actively engaging with the liaison service or being family members or friends of individuals who did. When interpreting the findings, it is essential to acknowledge that the sample represents a population with limited geographic variation and strong family and social ties.

Demographics

Fourteen participants took part in this study, all of whom self-identified as being a part of the GRT community over the age of 18 and had given birth in the United Kingdom at least once in the last 3 years. Each participant received an alpha-numeric identifier ranging P1 to P14. Demographics collected are presented below in Table 1. At the time of the interviews, the age range of participants was 18-30 years old, with all participants denoting their marital status as married. The completion or non-completion

of either primary or secondary school denotes education level. In the United Kingdom, primary school is for children aged 5 to 11 years, secondary school is for children aged 11 to 16 years, and sixth form, or college, is for ages 16 and beyond (UK Government, 2025). No participants in this study confirmed attendance in a Sixth Form school.

The summary statistics shown in Table 2 below indicate that half of the participants completed primary school, while only 21.4% completed secondary school. Collectively, the participants had a total of 32 pregnancies and 28 live births, indicating that 28.6% of participants had more pregnancies than live births.

Table 1

Demographics

Participant ID	Age	Marital Status	Education Level	Total Pregnancies	Total Live Births
P1	24	Married	Completed Primary	3	2
P2	28	Married	Completed Secondary	2	2
P3	26	Married	Completed Primary	3	3
P4	20	Married	Completed Primary	1	1
P5	22	Married	Did not complete Secondary	2	1
P6	23	Married	Did not complete Secondary	2	2

Participant ID	Age	Marital Status	Education Level	Total Pregnancies	Total Live Births
P7	30	Married	Did not complete Secondary	5	4
P8	26	Married	Completed Primary	3	3
P9	28	Married	Completed Secondary	2	2
P10	23	Married	Completed Primary	2	2
P11	30	Married	Did not complete Secondary	5	4
P12	23	Married	Completed Primary	3	3
P13	22	Married	Completed Secondary	1	1
P14	18	Married	Completed Primary	1	1

Table 2*Summary Demographic and Characteristics Statistics*

Characteristic	<i>n</i> (%) or Descriptive Statistic
Age (years)	
Mean	24.6
Median	23
Education Level	
Completed Primary School	7 (50%)
Did Not Complete Secondary School	4 (28.6%)
Completed Secondary School	3 (21.4%)
Reproductive History	
Total Pregnancies (Combined)	32
Total Live Births (Combined)	28
Participants with More Pregnancies Than Live Births	4 (28.6%)

Data Collection**Participants and Sampling**

Data collection for this study occurred between December 4, 2025, and December 24, 2025. Fourteen participants completed semistructured interviews using a researcher-created interview guide (see Appendix C). Recruitment began with the support of a local liaison team, who distributed recruitment posters during visits with the GRT population.

This approach resulted in the initial participants completing consent forms and scheduling their interviews.

At the end of these initial interviews, snowball sampling was used which included asking participants whether they had family members or friends who met the eligibility criteria. Snowball sampling is beneficial in studies where the target population may be challenging to engage, as it introduces the study via a party already known to potential participants (Palinkas et al., 2015). Participants who responded affirmatively received a link to the consent form along with a digital copy of the recruitment poster to share. Snowball sampling proved to be an essential recruitment strategy, as attempts to recruit participants without the involvement of a trusted intermediary known to the participants did not result in participation.

Data Collection Instrument

The instrument used for data collection in this study is a researcher-created interview guide (see Appendix C). The interview guide employs a semistructured format with open-ended questions and built-in prompts, which the researcher used as needed to elicit detailed accounts of participants' maternal care experiences within the NHS, culturally meaningful beliefs and practices related to pregnancy and birth, and personal definitions of maternal health.

The semistructured design made consistency across interviews possible, while still allowing flexibility to follow up on unanticipated topics as they emerged in participants' interviews. Unexpected issues were explored through unplanned prompts, resulting in data that was contextual and relevant to the participants' experiences.

Flexibility is crucial in qualitative research that uses focused ethnography, as it enables a reflexive research process, thus yielding rich data (Trundle & Phillips, 2023). Overall, the use of the interview guide facilitated the collection of detailed narratives that reflected participant's lived experiences and informed the study's research questions.

Interview Process

Upon completion of each consent form, the researcher reviewed the responses to confirm that the participant met the inclusion criteria. Once eligibility was confirmed, the researcher scheduled interviews according to each participant's preferences for the day and time. Before the interview, the researcher assigned each participant an alpha-numeric identifier (P1–P14) to protect privacy. Then, an individual folder for each participant on a password protected drive was created, where all study-related documents were stored. All interviews were conducted via Zoom and each audio recording was saved in the participant's designated folder on the secure drive. Interviews lasted between 30 and 45 minutes with the average length of time being 35 minutes. All participants completed their interviews, and no follow-up interviews or post-interview clarifications were required. Participants completed their interviews in a room from their own home either alone, or with a small child present. After each interview, the participant received a £15 Amazon e-voucher via email as a token of appreciation.

For transcription purposes, each audio recording was listened to at least three times. This process helped to ensure audio-to-text accuracy. The interview guide served as a template for transcription, thus maintaining a consistent structure across transcripts. Transcription was performed manually without the use of AI-assisted software. The

interviews did not deviate from the planned data collection process described in Chapter 3, nor were any unusual circumstances encountered.

Data Analysis

The data analysis process for this study was an exercise in striking a balance between structure and flexibility. This effort resulted in answering the research questions through a process of careful data review, data organization into codes, categories, and themes, and recognizing data saturation.

Data Organization

The first step in the analysis process involved uploading the carefully reviewed transcripts into the qualitative data analysis software NVivo 15. Each transcript was saved as a PDF file titled with the participant number followed by the word "Transcript" and stored in the Files section of NVivo, where all coding took place. Notes on potential codes were documented in a reflexive journal during the transcription process to support transparency. Recording decisions about analysis choices shows a clear path for code and theme development and strengthens the rigor and transparency of the analysis. This practice records why particular codes were applied and, equally important, why certain segments of data were not coded in specific ways, thereby reducing the influence of bias (Reyes et al., 2021). Once the transcripts were uploaded and the initial coding notes were organized, the analysis moved to the next stage.

Two-Cycle Coding Approach

Analysis followed a two-cycle coding approach as outlined by Saldaña (2021). This approach supports the identification of descriptive coded data, the organization of

codes into conceptual categories, and the synthesis of categories into broader themes (Saldaña, 2021). Using this structured process, the data is presented in a clear and structured manner that directly answers the research questions.

First-cycle coding began with entering the preliminary codes identified during transcription into the Codes section of NVivo. The codes section includes space on each code for reflexive notes to capture analytic observations alongside the coding process. A line-by-line review of each transcript then guided the application of existing codes or the development of new codes, which were immediately applied to the relevant data segments. First-cycle coding played a crucial role in assessing data saturation; therefore, transcription and initial coding were completed within 48 hours of each interview. By the completion of transcript review, an extensive list of codes emerged. These descriptive codes were a reflection of the participants' views and experiences, frequently drawing directly on participants' own language.

Second-cycle coding began with a review of the codebook created in NVivo and the passages recorded for each code. This review aimed to identify patterns, similarities, and relationships across codes (Saldaña, 2021). The emerging patterns were then grouped into specific conceptual categories, with related categories then grouped into broader themes. Each stage of organizing data into codes, categories, and themes remained closely aligned with the research questions, ensuring that the analysis stayed focused on addressing the study's aims (Saldaña, 2021). Table 3 (see below) presents the categories and themes, while Appendix E provides the complete list of codes, categories, and themes.

Table 3*Categories and Themes*

Category	Theme
Advocacy & Mediation	Family and Women as the Primary Care System
Family and Care & Stability	
Women's Authority in Care	
Gendered Role Boundaries	
Reproductive Experience	
Bodily Care Practices	Cultural Definition of Maternal Health and Responsibility
Food, Strength, & Recovery	
Maternal Responsibility Model	
Folk Belief – Objects & Luck	
Folk Belief – Spirit & External Influence	
Cultural Continuity & Pride	
Healthcare Interaction - Positive	Negotiated Encounters with the Healthcare System
Healthcare Interaction - Negative	
Education & Literacy Gaps	
System Barriers & Design Mismatch	
Technology Engagement	

Surveillance & Stigma	Surveillance, Stigma, and Conditional Dignity
Dignity & Respect	
Mobility	Mobility & Settlement
Settlement	

Data Saturation

Data collection and analysis occurred concurrently, with coding completed within 48 hours of each interview. This timeline was for the purpose of the early identification of recurring patterns that would indicate data saturation. Saturation is the point at which additional data no longer creates new codes or offers new insights. This suggests that the breadth of relevant information has been captured (Guest et al., 2020). By the 13th interview, the data no longer generated new codes, indicating saturation. The 14th interview, however, had already been scheduled and proceeded as planned. Conducting this interview reflected respect for the participant population, particularly given the initial challenges in securing engagement at the outset of the study.

Discrepant Cases

Throughout the analysis process, the study actively looked for the presence of discrepant cases. In qualitative research, discrepant cases refer to data that does not align with the guiding theoretical framework or that contradict dominant patterns within the dataset (Booth et al., 2012). The analysis did not identify any discrepant cases at any stage. If discrepant cases had emerged, the analysis would have coded and reported them

to deepen understanding of the phenomenon under study and to maintain transparency and trustworthiness.

Evidence of Trustworthiness

Examining a specific culture to more fully understand a phenomenon is the bedrock of focused ethnography. Conducting such research imposes essential ethical responsibilities on the researcher to ensure that their processes and analysis accurately represent the culture being studied through measures of trustworthiness. Specifically, the criteria of credibility, dependability, confirmability, and transferability are put in place to ensure that the findings accurately reflect the participant's lived experience and that decisions made during the analysis process support this.

Credibility

The ability to accurately reflect the participant's experience is crucial in establishing trustworthiness. This is achieved through credibility, a process that occurs when steps are taken to prioritize the reality that participants shared is reflected accurately (Stenfors et al., 2020). This study supported credibility through prolonged engagement with the data, consistent repetitive analysis, and member checking. All interviews were audio recorded, which allowed for the creation of verbatim transcripts. Next, I reviewed the transcripts, which not only served as the process for coding but also helped ensure accuracy and familiarize me with the participants' accounts. Member checking occurred after the final review of the transcript, when participants were sent the transcript for review and feedback. Overall, these practices ensured close alignment between participants' accounts and the findings presented in this study.

Dependability

Dependability refers to consistently applying the research process, specifically data collection and analysis (Ahmed, 2024). A standard indicator of dependability is that another researcher following the same methodology would arrive at the same conclusions (Ahmed, 2024). In this study, dependability was built into the research process by using the same semistructured interview guide for each participant. Additionally, keeping a reflexive journal allowed for the creation of an audit trail, making it possible to track how and why coding decisions were made and ensured they remained consistent. These steps supported dependability in the transparency of the research process.

Confirmability

Confirmability refers to the extent to which the findings of the study originate from participant data rather than the researcher's assumptions, biases, or preferences (Elo et al., 2014). In this study, confirmability was crucial given the focus on the cultural nature of GRT women's maternal care experiences and the interpretive nature of qualitative analysis. Keeping in mind the guiding principle of focused ethnography that conclusions must be grounded in the participants' accounts helped prevent cultural assumptions or the expectations of the CCT from shaping the findings (Trundle & Phillips, 2023). To support this, analytic decisions were documented throughout data analysis through coding records and reflexive notes. This created an audit trail of how interpretations developed over time. The analysis used participant quotes to demonstrate alignment between data and the findings presented. These practices support the

objectivity of the analytic process and indicate that the findings emerged from the data rather than being influenced by researcher bias.

Transferability

Transferability is the final consideration when addressing trustworthiness in qualitative research. It refers to the extent to which findings can be applied in other settings or to other populations (Stalmeijer et al., 2024). This study addressed transferability by using a purposeful selection of participants, based on clearly defined inclusion criteria, which established both the boundaries and the applicability of the findings. By focusing this study on GRT women in the United Kingdom who had a lived experience of maternal healthcare, the study was grounded in the specific cultural context in which GRT women reside. This study aimed for specificity over broad generalization. However, the conceptual insights from this study may be applicable to other culturally distinct populations navigating formal healthcare systems and may serve as a methodological guide for research with those populations.

Study Results

The results of this study originated from the careful analysis of data derived from semistructured interviews with GRT women in the United Kingdom who had given birth at least once in the last 3 years. The analysis followed a two-cycle coding process that began with detailed first-cycle coding of interview transcripts and progressed to the development of broader categories through pattern coding (Saldaña, 2021). These categories were then synthesized into overarching themes that developed across participants' accounts while at the same time honoring the important distinctions in

individual experience. Appendix E provides the complete table of codes, categories, and themes, and Table 5 summarizes the relationships among them.

The themes represent structured ways in which participants described their experiences of maternal care and articulated their understanding of maternal health within the context of their cultural beliefs and family structures. Rather than highlighting individual findings, the themes reflect collective aspects of care that illustrate how maternal health is understood, acted upon, and negotiated within the GRT community. Identifying these themes was essential in understanding the phenomenon examined in the research questions, as they show how cultural values and traditions, family systems, and institutional encounters intersect to shape women's experiences of pregnancy, birth, and the postpartum period.

Theme 1

Family and Women as the Primary Care System

Participants in this study described maternal care as a way of life existing within a women-centered, family-based system of knowledge and support. All participants identified GRT mothers, grandmothers, aunts, and other female relatives as the primary source of emotional and physical support during pregnancy, childbirth, and the postpartum period. They were revered and sought out for their guidance during these times and brought their knowledge to the concept of maternal care. The analysis of this theme describes how the participants understood maternal care as originating from their familiar relationships, being collective, and grounded in familiarity, with family

members, particularly older female relatives, occupying central and important roles in guiding and supporting pregnancy, childbirth, and postpartum care.

Participants frequently described learning from an early age how to manage pregnancy by observing female family members and other GRT women who lived on the same site. Several participants spoke about growing up surrounded by pregnant GRT women and learning about the expectations and unspoken rules via exposure rather than formal instruction. P1 reflected, "I was raised mostly by Mam and my aunties... I learned everything from the women." The same participant further explained how experience equated to knowledge for the women in the family, stating, "When you have been pregnant that many times, you know some stuff". Once you have had the pregnancy experience, you join the maternal figures in the family as stated by P5, "I guess being pregnant makes you a part of the other women. Like you are a part of the club or something." The pregnancy experience was not an individual experience in the GRT, but part of something larger, a shared experience that is revered. These participant accounts illustrate how knowledge and experience in maternal care was understood as being rooted in family life rather than external formal expertise or training.

Another essential role was to support a woman during her pregnancy, childbirth, and postpartum experience by providing emotional stability. Participants described pregnancy as something that existed within a shared environment, where reassurance and support came from the collective experiences of their female family members. P10 explained, "It was also nice having them around because most of them had babies before, so no matter how I was feeling, someone had felt that way before." P14 emphasized the

comfort of shared presence, noting that, "Knowing that they had been through it and were helping me made me feel a lot better." These answers demonstrate how the presence of family provided a source of emotional stability and support during pregnancy.

Central to this theme is understanding the role that maternal family figures play in the pregnancy of the participants. Many participants stated that family members understood them in ways others could not, thereby relating quality care with the familiarity and the emotional love that only family can provide. P1 captured this sentiment when explaining why she didn't feel healthcare workers could provide the same care her family could by saying, "they don't know what I feel, you know?" It is this sense of being known and understood that shaped how women experienced care, felt supported, and made decisions during pregnancy.

Relationship to Research Question 1

This theme partially supports answering RQ1: How do women who self-identify as GRT who live in the United Kingdom and have given birth at least once in the past 3 years describe their lived experiences with maternal care received from the National Health Service within the context of their cultural beliefs and practices?

Participants consistently described their maternal care experiences in the formal healthcare setting by comparing it to their own family-based systems led by women. In these accounts, care was understood as collective and relational, while grounding it in the broader pregnancy experience of their family. For participants, maternal care was not defined as something that existed solely through formal healthcare encounters, but

through existing family networks that provided knowledge, advocacy, and emotional support.

These findings do not dismiss the role and expertise of professional healthcare workers. Instead, they show that participant's experiences of maternal care were strongly shaped by culturally rooted family practices that operated alongside, and at times separately from, formal healthcare services. This perspective provides important insight into how maternal care is experienced and understood within the GRT community.

Theme 2

Cultural Definitions of Maternal Health and Responsibility

Participant answer's centered on this theme examined how participants defined maternal health and the responsibilities they associated with it, as influenced by their cultural beliefs and practices. Maternal health was not defined by medical indicators. Rather, the participants described it as a moral, emotional, and behavioral state of being shaped by culturally learned expectations and practices about care, protection, and actions during pregnancy. Interview answers revealed maternal responsibility to be an ongoing exercise of vigilance, self-restraint, and adherence to multi-generational practices, and was achieved through constant family support. The analysis of these findings show how cultural identity shaped women's understanding of what it meant to be a healthy mother and how maternal health was a reflection of daily actions, beliefs, and relationships. Examining these accounts provides insight into the cultural beliefs and practices that defined maternal care among GRT women.

The responsibility that participants felt regarding the outcome of their pregnancies was strong and served as a motivating factor for adhering to the guidelines set forth by family and cultural customs. P11 explained this plainly, "The baby is a part of you, so if the baby comes out with something wrong, it has to be because of what you've done or didn't do." This positioned maternal health as a moral obligation, where responsibility rested squarely with the mother to maintain calm, avoid harm, and behave appropriately throughout her pregnancy. In expressing her belief about what a healthy pregnancy entailed, P10 explained it as follows, "Making sure that you are strong and healthy so that the baby comes out healthy and not sick." This statement highlights the connection between the mother's health and the baby's health.

A key aspect of emotional maternal responsibility that emerged was the ability to regulate feelings and avoid stressful situations. According to many of the participants, staying calm and avoiding stress was not a matter of personal preference, they believed it directly affected their baby's wellbeing, a belief reinforced by older relatives. Many participants spoke about deliberately avoiding arguments, stressful situations, and strong negative emotions because of the perceived negative impact on the unborn child. P1 recalled being told, "Don't be arguin', it'll harm the baby." Later, when discussing what it means to have a healthy pregnancy, the same participant explained, "That I'm calm so the baby will be happy." Several participants stated their belief that their emotional state directly affected the infant's temperament, with one stating that experiencing stress while pregnant would result in "a baby born all cryin' and cranky" as recalled by P1. These accounts reflect a belief shared by many GRT women that maternal emotions pass

directly from mother to baby. This belief places an expectation on the mothers that they manage their feelings as part of their health responsibilities.

The physical component of maternal responsibility is observed in tales of bodily protection. Participants described carefully regulating and often limiting their physical movement, ensuring there is time for rest, and minimizing bodily exposure to prevent harm to the baby. Common practices included avoiding lifting, staying off one's feet late in pregnancy, and keeping the body, particularly the belly, warm. P8 explained what her grandmother told her on the subject, "You shouldn't be lifting or bending down... that can hurt the baby", while P9 noted how family helps during this restriction, "You can't lift things or do housework when you are big, so the women help you with that too." The importance of this type of physical rest was supported by tales from family members warning of the outcome of these rules not being followed, as highlighted by P11, "I remember hearing stories when I was younger about babies being born with the cord around them all tight, and that was because the Mum kept lifting things." In addition to restraining from physical activities, bodily protection extended to limiting what are believed to be harmful environmental factors. P4 expressed this belief by saying a part of what makes a healthy pregnancy "was about keeping really warm, cause the baby could get sick." These practices were viewed as preventative rather than reactive, emphasizing that the responsibility of the mother to regulate herself emotionally and physically was a normalized part of maternal care that occurred from the beginning of her pregnancy.

Alongside bodily protection, participants described food as a crucial factor in ensuring maternal strength, which in turn results in a strong and healthy baby. Practices

linked with food, specifically their nutritional value, were deeply embedded within GRT family traditions and often carried an important meaning beyond sustenance. Women spoke about eating specific foods, such as soups, stews, and broths, prepared by older relatives for the purpose of building strength and to support the baby's development. P1 shared, "My family would make broths for me to keep me strong, that's important", while P12 explained that certain meals were prepared because "they said it would make my bones strong to withstand birth and make the baby strong too." These practices framed food as both a basic necessity and as medicine, reinforcing the idea that maternal health involved intentional food consumption guided by shared and inherited family knowledge.

Protective practices found in folk beliefs add cultural and historical context to the understanding of maternal responsibility and its practice. Participants described using charms and blessed objects to protect themselves and their babies from harm or bad luck. As with other aspects of pregnancy and childbirth, knowledge, folk practices, and the creation of charms and remedies are passed down matrilineally from one generation to the next. Iron objects, red strings, blessed crosses, and herbal washes were commonly mentioned as protective traditions. P10 explained, "I think iron is supposed to be a shield-like thing. It protects you. Nothing bad will come near you if you have it", while P8 described the personal effect of keeping a charm close during pregnancy, stating, "I wouldn't have been happy if I didn't have those good luck things." These practices were not always believed to be literal protective methods. Instead, participants described them as beliefs and tokens that offered comfort and a sense of connection to their family and

cultural heritage despite feeling uncertain about their legitimacy. P13 stated this belief when she said, "I know it's probably a silly tradition, but the red wool bracelet was important to me." Charms and protections represent generations of knowledge and the hope for a healthy baby.

Beliefs about spiritual and external influences shaped maternal behavior and triggered protective actions. Several participants spoke about avoiding graveyards, or people believed to possess harmful intent, often referred to as "evil" or malevolent spirits. P6 explained, "If a pregnant lady goes near a dead body or even walks in a graveyard... souls not at rest can get inside the baby". Negative influences from what are believed to be "evil" are a daily reality, as explained by P8 when discussing her experiences in shops: "They gave you the evil eye. They looked at you with evil intent." As prevalent as the existence of evil intent is, so is the remedy in the form of a beaded bracelet that P8 described. "All that evil bounces off and goes right back at them." Participant recollections describe how maternal health is seen to be vulnerable to unseen forces, confirming the need for protection through culturally meaningful practices.

Religious belief and practices emerged as an essential addition to cultural approaches to maternal responsibility and protection. For some participants, religious rites were not symbolic and traditional, but urgent and meaningful actions tied to wellbeing and moral responsibility. P10 described baptism as something that should occur immediately after birth, stating, "Baptizing the baby, we made the arrangements pretty soon after he was born." P12 placed the importance of spiritual intervention above clinical care when faced with possible medical complications with her baby, explaining,

“I wanted a priest to come in right away, but they said it was important that they look at her heart first.” Examining these accounts, it becomes apparent that religious practices operate alongside cultural beliefs and charms, making religious faith an essential component of GRT identity.

Ultimately, participants viewed these beliefs and practices as integral to a broader connection with their cultural heritage. Participating in traditional maternal practices was often described as a way to honor the knowledge of older generations. P10 reflected on modern medicine and remedies given by her grandmother, saying, "We had those things before there was medicine... I think we can have both." Meanwhile, P13 stated, "I liked doing things that everyone before me has done." These statements highlight the fact that these culture-based maternal health practices are not outdated or irrelevant customs. Instead, the practices are living expressions of cultural identity that coexist alongside modern healthcare. When viewing maternal health for the GRT population holistically, a clear picture begins to form showing that health extends beyond the baby's outcomes and includes the preservation of cultural knowledge and traditions.

Relationship to Research Question 2

This theme directly supports answering RQ2,
How do women who self-identify as GRT and live in the United Kingdom who have given birth at least once in the past 3 years define maternal health and how is the definition influenced by cultural identity?

When analyzing these findings together, a narrative forms of maternal health being a culturally grounded system that encourages maternal responsibility, emotional

regulation, and bodily protection. This theme addresses the research question by showing how women's definitions of maternal health are formed by cultural identity and manifest through everyday practices that control behavior, emotion, and care throughout pregnancy.

Theme 3

Negotiated Encounters with the Healthcare System

Study participants described encounters with maternity services as experiences that often required ongoing negotiation. The need for negotiations emerged when expectations of care, communication styles, and daily realities did not align with the realities of services being delivered, or with the actions of healthcare workers. During interviews, women described encountering authority, trying to understand information, and decision-making in ways that allowed for both their desire to engage with institutional care and the misalignment they experienced within those settings when considering the realities of their culture and way of life. Participant descriptions indicated that how power, communication, and mediation shaped these negotiated encounters, both positively and negatively.

Overall, participants described scenarios where the authority over their own health was held by the healthcare professionals rather than themselves. P3 explained when recalling interactions with the maternity healthcare service, "They just tell you what's happening, and you're meant to agree. You don't really get asked." P8 recalled her reluctance to question professional instructions, stating, "I didn't feel like I could say no because they're the doctors and they know best, don't they?" P12 described her

experience of receiving distressing news about her baby as lacking the emotional support from the healthcare professionals she was looking for, "They told me there might be a problem with the baby's heart, possibly a hole. They did not say it kindly." Interview answers illustrate how the perception of professional authority directly impacts the participants. The belief in this authority then limited meaningful interactions and left participants feeling separated from decisions about their own care.

Communication appeared to be a crucial factor in determining whether healthcare encounters met or failed to meet the participants' needs. Communication that was heavy on medical language was difficult for participants to understand and left them feeling reluctant to ask for clarification. P7 explained this experience, saying, "They use big words and talk fast, and I just nod because I don't want to look stupid." P1 described a similar experience by saying, "I didn't understand what they were saying half the time, so I just kept quiet." However, clear communication stood out as enabling positive encounters. P10 recalled such an experience: "When someone actually explained it plain, it made a big difference." Communication is how information is given and subsequently understood. Communication plays a crucial role in shaping participants' engagement with healthcare and influences whether encounters feel positive or negative.

Some participants used mediation through professionals or family to navigate healthcare encounters when direct communication felt difficult or other actions failed. Participants described relatives as intermediaries who helped interpret information, press for clarity, or buffer stressful interactions. P5 recalled a positive experience with her local midwives being the inclusion of her mother in discussions, "The midwives at the surgery

always talked to both me and Mam, all together like." P1 stated, "Mam was with me, and she backed me up" when the topic of a missed appointment came up with receptionists. Liaisons are professionals who work for local government; the ones referred to in this study work specifically with the GRT community to support them in accessing services or navigating institutional systems. In discussing her experience with a local liaison who accompanied her to her midwife's appointment, P6 explained, "She came with me and explained it all proper, not like the doctors do". P4 explained how the presence of a liaison positively changed her experience during her midwife appointment, stating, "When she was there, they spoke different, slower, and I could actually understand what was going on." Meanwhile, P2 recognized her reliance on the liaison's ability to convey what she herself felt she could not articulate: "I let her talk because I didn't know how to say it myself." These accounts suggest that mediation enabled participation in care by reducing communication barriers and emotional strain, therefore allowing negotiation to occur without confrontation.

Facilitating negotiations often came from individuals within the healthcare, most often those who became familiar with the participants over the course of repeated pregnancies. In these cases, mediation prompted accommodation when routine care or expectations conflicted with participants' ways of living. P11 described an interaction between a midwife she knew from past pregnancies and the dietician to whom she was referred. "She knew how we live and told them, so they stopped pushing things that wouldn't work for me." The result of this meaningful interaction was a negotiation

between professionals for the purpose of the participant receiving care that was realistic for her.

Meanwhile, P5 spoke fondly about a midwife who she felt took the time to get to know her without judgment. When that relationship was established, P5 noted a positive shift in interactions, saying, “Once they knew where I was coming from, it was easier to deal with them.” These accounts demonstrate how familiarity and professional consistency within the healthcare system allowed care to be provided in ways that acknowledged participants’ realities. In these examples, negotiation came through trust built over time and professionals’ willingness to form relationships with participants and advocate on their behalf within the system.

Relationship to Research Question 1

This theme directly supports answering RQ1, How do women who self-identify as GRT who live in the United Kingdom and have given birth at least once in the past 3 years describe their lived experiences with maternal care received from the National Health Service within the context of their cultural beliefs and practices?

The theme of negotiated encounters plays a significant role in addressing RQ1 by examining how and why participants had positive and negative experiences with the NHS. These negotiations were shaped by participants’ familiarity with healthcare professionals and the trust they felt as a result of positive encounters. Negotiations for the participants were not explicitly focused on clinical outcomes; instead, they were a way to

receive healthcare that was meaningful to them, information in a way that they understood, and recommendations and instructions that fit their culture.

Theme 4

Surveillance, Stigma, and Conditional Dignity

Participants described their lives, including their experiences of maternal care, as shaped by an awareness of surveillance, which often led to the anticipation of judgment. Surveillance is a complex reality for many in the GRT population. It can take the form of a sense of being watched and judged with dire consequences, such as the involvement of social services reusing in the removal of children from the home (UK Parliament, 2019). Surveillance was described as including profiling concerns that result discriminatory acts, such as non-GRT individuals assuming GRT will commit stereotypical crimes including theft and violence (Claisse et al., 2024). The experiences participants described went far beyond individual encounters and highlight the long-standing social experiences of stigma associated with GRT identity. In maternity care settings, participants expressed their desire for dignity, the kind that originates from being respected by those around them. Conditional dignity occurs when dignity, being the validation of a person for being themselves and thus treated respectfully, is entirely contingent upon a set of circumstances or conditions (Frantz et al., 2025). In many of the participants' accounts, dignity was conditionally given when participants appeared settled, familiar, or compliant. The analysis of this theme explains how surveillance and stigma influenced how healthcare professionals delivered care and how participants received it.

Many participants described anticipating being judged before it happened, which led them to limit questions, suppress concerns, or avoid drawing attention to themselves. P3 spoke of this learned self-silencing when recalling encounters with non-GRT individuals: “I learned to keep my head down” and “you choose which battles you fight because if you push too hard, they start lookin ’at you like you’re difficult”. Past experiences and their resulting learned behavior directly impacted not only on how the participants in this study engaged with the broader society, but also their healthcare encounters. This fear of being perceived as “difficult” adds further nuance to the earlier examples of power imbalances in negotiated healthcare encounters. Participants hesitated to challenge professional authority even when healthcare felt misaligned with their personal beliefs and wishes out of fear. P4 described this belief in the maternity setting, stating, “I don’t want to be difficult, so I let things happen even when I wasn’t comfortable.” These recollections demonstrate how anticipated surveillance and judgment shaped behavior and stifled the participants’ belief that they could advocate for themselves in the healthcare setting.

Surveillance was most strongly felt during the safeguarding and assessment processes where questions to assess personal and domestic-related risks are asked (NHS England, 2023), where participants admitted they were unsure whether the questions were routine or the result of GRT-based assumptions. P10 expressed frustration with repeated questioning: “Why do I have to answer them all the time?...maybe they just asked me all the time because I’m a Traveller.” P12 similarly recalled, “When they asked repeatedly if I understood what they were telling me about the baby’s tests, I felt judged”

and admitted, "I feared they might think I could not care for my baby." These concerns often resulted in the fear of child removal, influencing how participants perceived interactions with healthcare professionals. P9 stated this was her fear because her baby was born early and required a short hospital stay, "I thought that it was my fault the baby was on the ward and that social services would look into it." These fears reinforced behaviors of silence and compliance, linking surveillance directly to restricted and unauthentic participation in care.

Participants recalled experiences in which the perception of being treated with dignity and respect was conditional; the condition being that the healthcare professional had become familiar with them, and/or they viewed the participant was no longer transient. P11 noted this difference when explaining how attitudes toward her changed once she became settled: "But when we live in houses right next to them, they don't seem to care, and life is a bit easier." Others connected positive treatment directly to being seen as an individual rather than as a GRT. P13 benefited from familiarity by having the same midwife team for her second baby as she did for her first: "I felt like I was seen for who I was and not just as a Traveller." Statements such as these suggest that dignity, as experienced through being respected, was not automatically given; instead, it was earned through familiarity, proximity, or repeated exposure.

Participants articulated what they wanted healthcare workers to know about caring for the GRT population. Overwhelmingly, they spoke of the desire to have dignity and respectful care achieved by reducing stigma. P1 stated, "Treat me like a normal person", while P14 emphasized the emotional impact of judgment, saying, "That your

judgment hurts" and "I felt embarrassed." Others highlighted the importance of being asked rather than assumed. P11 explained, "Talk to us, ask us what we want... if we have old ways it's ok to ask... just ask instead of saying no." The solution that P8 suggested and was echoed by others was formal training on GRT culture for healthcare professionals, "...and teaching some of them about Travellers." These moments of dignity, while less frequent, demonstrate how respectful engagement and cultural knowledge could counteract the effects of surveillance and stigma.

Relationship to Research Questions 1 & 2

This theme directly supports answering RQ1,

How do women who self-identify as GRT who live in the United Kingdom and have given birth at least once in the past 3 years describe their lived experiences with maternal care received from the National Health Service within the context of their cultural beliefs and practices?

This theme partially supports answering RQ2,

How do women who self-identify as GRT and live in the United Kingdom who have given birth at least once in the past 3 years define maternal health and how is the definition influenced by cultural identity?

These participant accounts demonstrate how they experienced surveillance and stigma, and the effects that had on them. Healthcare encounters brought fear of surveillance, and perceived judgment left many feeling as though they had no dignity in their own maternal healthcare journey. Many participants chose to remain silent due to anticipating judgment. In these situations, silence works alongside earlier incidents in

which fear of questioning authority becomes a barrier to receiving the healthcare they want. Though some experienced dignity and respect, it was conditional and granted only through familiarity, settlement, or perceived compliance with the healthcare system. This theme addresses both research questions by showing how maternal care was experienced through clinical interactions and the meanings attached to broader social interactions that reflected on identity, visibility, and respect.

Theme 5

Mobility and Settlement

The acts of mobility and settlement shaped participants' experiences of healthcare. In many interviews, participants recalled transience as a normalized and often valued part of childhood and early family life, with several speaking about moving several times a year. Meanwhile, for those who experienced settlement, this emerged as a significant shift that changed relationships with healthcare services. These experiences affected how participants accessed care and how professionals perceived them. For those participants who experienced both mobility and settlement, their experiences framed them as conditions that carried distinct social meanings and consequences within healthcare settings.

When participants spoke about mobility during childhood, they did so with the belief that it was ordinary and routine. These experiences were shaped by the need to rely on family above all else. P5 reflected, "We were always movin'. Sometimes we'd barely get settled before we had to leave... It was just normal." P1 had similar sentiments, "We were never settled long enough for me or my sisters to feel like any place belonged to us,

like a home,” while also highlighting the importance of family, adding, “Everything is just for a short time except the people you came with.” For participants who moved frequently, stability is defined as physical proximity to family. The reliance on family shaped early understandings of care as something carried with the family rather than tied to institutions or locations.

For participants who grew up settled or became settled later, being settled affected how they related to the healthcare system. As noted in Theme 4, being settled also affected how participants believed those systems perceived them. Several women described settlement as enabling continuity, familiarity, and recognition within healthcare encounters. P11 explained, “When I was 20, my husband and my Da both decided to settle... being settled gives us a chance to be a part of the village.” Meanwhile, P13 compared her own positive healthcare experience as a settled GRT woman to those of family members who were not settled,

“I think how different it was from what I've heard from cousins and other people who actually travel, you know. They have people who are much nastier to them, and sometimes they have a hard time understanding things. Mine wasn't anything like that.”

These recollections point to settlement as a condition that allowed participants to develop longer-term relationships with their community as well as with healthcare professionals, reducing negative experiences during pregnancy and childbirth.

Relationship to Research Questions 1

This theme directly supports answering RQ1,

How do women who self-identify as GRT who live in the United Kingdom and have given birth at least once in the past 3 years describe their lived experiences with maternal care received from the National Health Service within the context of their cultural beliefs and practices?

These accounts suggest that mobility and settlement influence how the participant experiences maternal care. The experiences occur because of the meanings attached to stability, familiarity, and legitimacy within institutional systems, not through the act of movement itself. Settlement allowed for continuity and easy engagement within social situations and with maternity care. For participants who are not settled, mobility meant heightened vigilance and reinforced reliance on family-based care structures.

Understanding the complex relationship between residence stability and institutional relationships, Theme 5 contributes to answering RQ1 by demonstrating how the consequences of movement and settlement shaped GRT women lived experiences of maternal care within the NHS.

Research Questions

RQ1: How do women who self-identify as GRT who live in the United Kingdom and have given birth at least once in the past 3 years describe their lived experiences with maternal care received from the National Health Service within the context of their cultural beliefs and practices?

Participants interviewed for this study described their experiences with NHS maternal care by comparing the care they received from professionals with their own culturally based way of life, whether they felt cared for, and whether they were able to engage in

shared decision-making with their family, rather than by clinical outcomes, Encounters with maternity services were experienced as positive when professionals recognized and supported maternal-led family structures rooted in cultural traditions, and as difficult when institutional expectations demanded compliance with protocol over cultural and family tradition, and professional authority over collective family involvement. Many women described their experiences of care through acts of navigation and negotiation. Prior experiences of judgment and surveillance led participants to navigate care cautiously, often moderating their behavior to avoid further judgment, adding to stress and a negative maternal health experience. Meanwhile, negotiation facilitated by familiar staff or liaison workers played a central role in shaping positive care experiences, particularly for women who were settled and known to services.

RQ2: How do women who self-identify as GRT and live in the United Kingdom who have given birth at least once in the past 3 years define maternal health and how is the definition influenced by cultural identity?

Maternal health, as defined by the participants, is a culture-based responsibility for the mother that goes beyond medical outcomes and includes emotional regulation, protection, and continuity of tradition. Women defined maternal health as an entire lifestyle during pregnancy, one in which they actively maintain calmness, vigilance, and stoicism, and adhere to inherited knowledge, with a strong emphasis on the mother's influence on the baby's well-being. Cultural identity shaped these practices through everyday actions such as food preparation and bodily monitoring. Vital to the participant's definition of maternal health is the belief that traditional folk practices and

religious observances function as protective measures rather than symbolic traditions, and that they are necessary for the mother's ability to ensure her baby's health. These definitions positioned maternal health as rooted in family, culture, and responsibility, rather than confined solely to clinical care.

Summary

The research conducted for this study examined how women who self-identified as GRT described their experiences of maternal care within the NHS and how they defined maternal health within the context of their cultural beliefs and practices. Throughout the interviews, participants explained pregnancy and childbirth as something that existed within family-based systems of care led by women, where authority, knowledge, and responsibility were passed down through generations. Furthermore, it existed in a space of collective family support, moral obligation, and culturally grounded expectations around behavior and protection. Women described drawing on family knowledge and practices alongside formal healthcare, though this union of practices became a source of negative experiences when the care received from healthcare practitioners felt misaligned with their ways of living and culture.

Participants' experiences with NHS maternity services were often determined by negotiation and compromise to achieve what they felt was a positive experience. Some participants recalled moderating themselves in appointments by remaining silent or complying without question due to fear of judgment, surveillance, or being perceived as difficult. At the same time, flexibility, familiarity, and clear explanations from professionals supported more positive experiences and willingness to compromise. Study

participants defined maternal health as a period during which the entire family, not just the mother, shared the responsibility of ensuring the delivery of a healthy baby through cultural traditions and beliefs passed down through the generations. Chapter 5 will consist of an examination of these results through the theoretical framework and existing literature, explore limitations and trustworthiness, present the Sunrise Enabler Model using the study's findings, and offer recommendations and implications for positive social change for GRT communities and other marginalized populations.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative study was to explore GRT women's perceptions and experiences of maternal care in the United Kingdom. In this focused ethnographic study, semistructured interviews were used to examine how GRT women experienced maternal care through a cultural lens and how cultural context shaped their definitions of maternal care. Previous studies examined social determinants of health and health disparities among GRT populations; however, none specifically examined how culture shapes maternal health among GRT women. The analysis used CCT to frame maternal care as a series of encounters in which participants negotiated healthcare interactions to preserve culturally grounded practices.

Semistructured interviews with 14 GRT women in the United Kingdom who had given birth at least once in the past 3 years provided the data needed to answer the research questions. Local liaison groups with established links to the GRT community supported recruitment. All interviews were conducted via Zoom, and transcripts were analyzed using Saldaña's two-cycle coding process.

The analysis conducted for this study answered two research questions:

RQ1: How do women who self-identify as GRT who live in the United Kingdom and have given birth at least once in the past 3 years describe their lived experiences with maternal care received from the National Health Service within the context of their cultural beliefs and practices?

RQ2: How do women who self-identify as GRT and live in the United Kingdom who have given birth at least once in the past 3 years define maternal health and how is the definition influenced by cultural identity?

I identified five themes during analysis: Women as the Primary Care System, Cultural Definitions of Maternal Health and Responsibility, Negotiated Encounters with the Healthcare System, Surveillance, Stigma, and Conditional Dignity, and Mobility and Settlement. Chapter 5 includes analysis of how the findings address gaps in the literature and interpretation of the findings through the lens of Cultural Care Theory to demonstrate a pathway for culturally congruent care that preserves tradition and upholds dignity. Chapter 5 also includes a proposed GRT maternal care model using the Sunrise Enabler. The remainder of Chapter 5 includes study limitations, recommendations grounded in the results, and implications for social change.

Interpretation of the Findings

Existing literature documents significant health disparities among GRT populations and supports the need for the study presented in this dissertation. Known health inequities are rooted in institutional exclusion, discrimination, and systems that do not align with the needs of transient and marginalized populations (Friends, Families and Travellers, 2022; Heaslip et al., 2019). The CCT has documented successes in identifying structural barriers to healthcare engagement through a cultural lens (Nascimento et al., 2020). However, neither the existing literature on GRT health nor prior applications of CCT have examined the specific intersection of GRT cultural identity and maternal

health. The findings fill this gap and contribute to the knowledge base on culturally congruent maternal care for GRT women.

Comparison to the Literature

Literature on GRT maternal health often focuses on clinical outcomes or offers broad descriptions of barriers to access and engagement. The findings of this study align with existing literature in demonstrating the persistence of health inequities and mistrust within maternal care. Study participants had a combined total of 32 pregnancies and 28 live births, showing that 28.6% had more pregnancies than live births. This statistic aligns with national evidence that one in five GRT mothers experience the loss of a child (UK Parliament, 2019). This study contributes an ethnographic-based exploration of the culturally grounded mechanisms that contribute towards these inequities and create mistrust. By identifying these mechanisms, patterns of behavior and engagement can be understood in relation to their cultural and social origins rather than interpreted solely through their outcomes.

Barriers to accessing care are often cited as a leading cause of poor maternal health outcomes among GRT populations. The existing literature commonly identifies institutional and policy-related barriers as the cause of poor outcomes. Barriers identified include digital exclusion, fines for missed appointments, transportation difficulties, and delays in care associated with nomadic living (Friends, Families and Travellers, 2022). The findings of this study align with this body of work by identifying challenges related to technology-based appointment systems and difficulties receiving time-sensitive communications due to address changes. What this study adds is a distinction between

barriers to access and the underlying conditions of care. All participants in this study engaged with maternity services; however, the quality of care they received often depended on healthcare professionals' approach. Familiarity with the participant appeared to reduce fears of judgment and enabled negotiation between participants and professionals, resulting in care that aligned more closely with participants' cultural expectations. In contrast, those without this familiarity noted a distinct lack of dignity and a tendency to remain silent during encounters. Therefore, barriers to access are not the sole cause of a lack of engagement or poor health outcomes; it is the conditional care that both GRT women and healthcare professionals must align with to promote culturally congruent care.

In addition to identifying the roots of access-related barriers, I examined how stigma manifests within healthcare interactions and the behaviors that emerge in response. Experiences of judgement, mistrust, and racism are well documented in the healthcare experiences of GRT populations (Heaslip et al., 2019), and some GRT individuals conceal or deny their identity due to prior experiences of stigma in healthcare settings (Townsend et al., 2020). The analysis showed no evidence that participants hid their GRT identity; participants described how stigma shaped behavior during healthcare encounters. Study participants reported a fear of judgment through tone, questions, and the dismissal of reported feelings, leading them to remain silent during encounters or to agree with policy and procedures they either do not understand or do not agree with. Silence then becomes a mechanism in limiting engagement and adding to the experiences

that GRT mothers draw upon when they anticipate stigma and judgment in their encounters.

Residential mobility appears in the literature as a disruptive factor in GRT healthcare. This disruption appears via challenges with appointment setting as notifications are sometimes sent to the incorrect address, and exclusion from services that assume a consistent residence. Settling into a permanent address is frequently presented as the solution to improving healthcare engagement (Townsend et al., 2020). Building on findings on stigma, this interpretation offers an alternative explanation. Dignity and respect within maternal care were experienced as conditional outcomes in this study, occurring only when the participants were known to services through repeated engagement or perceived as compliant.

This study indicates that trust and dignity are fostered by healthcare professionals' actions rather than by the participants' addresses. Although familiarity often facilitated these experiences, participants' engagement appeared to be driven by how they were treated during encounters, signifying that a learned behavior on the healthcare professional's side is the solution. At its core, culturally congruent care requires healthcare professionals to understand GRT culture and approach care encounters with flexibility and willingness to accommodate differences. Participants reflected on their desire to be treated as individuals rather than as stereotypes, suggesting that meaningful encounters in GRT maternal care will result from relational and systemic change at the personal level.

Applicability of Findings to CCT

CCT provides a theoretical framework for interpreting how GRT women understand and navigate maternal care as an experience rooted in culture and tradition rather than a series of clinical encounters. Within this framework, health and how it is experienced, how health behaviors form and are enacted, how meaning is attributed, and how health expectations are shaped remain grounded in culture. CCT analyzes culturally congruent care through three action modes: cultural care preservation/maintenance, cultural care accommodation/negotiation, and cultural care repatterning/restructuring (McFarland & Wehbe-Alamah, 2019). In this study, the analysis focuses on cultural care preservation/maintenance and cultural care accommodation/negotiation, as it did not include healthcare practitioners or a systems-level analysis.

As discussed previously, existing literature about GRT maternal health focuses on known barriers and social determinants of health. This study used a focused ethnographic approach because it elicits and analyzes participants' experiences and meanings regarding a specific topic within a cultural context (Black et al., 2021; Trundle & Phillips, 2023). Using this approach, CCT helps explain why barriers exist and persist by examining how culture shapes decision-making, behaviors, and beliefs. To elicit this information, the study's interview guide aligned questions with the core attributes of CCT (see Appendix D, Table 5). This theory supports a culturally specific view of health, allowing greater understanding of actions taken to preserve traditional practices and beliefs, and highlighting areas where negotiation can occur between the population and healthcare professionals.

Cultural Care Preservation and Maintenance

Practices sought to preserve

Participants described maternal care as a normal aspect of family life that is firmly grounded in a maternal-led family system. In this family system, women share generational knowledge, monitor bodily safety, and support decision making. Existing literature describes kinship bonds as a grounding force that supports pregnant GRT women emotionally and physically, reinforces cultural traditions, and functions as a shield against institutional systems the collective family group perceives as unsafe (McFadden et al., 2018; Parry et al., 2007). In the context of CCT, the functions of the family group are placed in the preservation and maintenance category, as they are a necessary and routine part of the maternal experience required to safeguard the mother and support the baby's wellbeing in culturally meaningful ways, rather than optional preferences. CCT literature further demonstrates that healthcare becomes more effective, reflected in improved engagement and outcomes, when professionals recognize family structures as agents of care and incorporate them into the healthcare experience (Nascimento et al., 2020). Participants described the family system as a stabilizing source of safety and dignity during healthcare encounters. Participants also described maternal responsibility, defined as the belief that a mother's actions determine the baby's health, as a culturally learned expectation. The actions appear as behavior regulation, protective routines, and the setting of emotional and physical boundaries. Participants described help-seeking behaviors as maternal-based, with the expectation that older generations inform and advise younger women in all areas related to pregnancy and childbirth, with

support resting in cultural practices handed down through generations; therefore, these practices, taken as cultural norms and guided by maternal authority, serve as a vehicle that drives the preservation of GRT culture within a healthcare setting.

Participants were asked questions about cultural practices and traditions that held meaning for them related to health and pregnancy. Reports of folk practices rooted in GRT tradition and Catholic spirituality offered a view of maternal care that highlights the connection between physical actions for protection and intangible ones, including talismans for protection, lighting candles for hope, and specific foods believed to ensure an easy delivery and a healthy baby. Participants did not describe these practices and beliefs as symbolic, but as essential practices to ensure their baby's health, a belief reinforced by their family systems. In the CCT framework, these folk practices align with the CCT concept of a generic care system, a factor that is necessary for defining how culture can be maintained and preserved alongside professional healthcare (McFarland & Wehbe-Alamah, 2019). To create a culturally congruent care model, clinicians must support these practices without judgment and negotiate compromises that preserve culturally meaningful care practices that are delivered alongside professional maternal healthcare.

Preservation supports wellbeing

Analyzing participant's accounts revealed that preservation and maintenance supported the participant's mental and physical wellbeing through three connected pathways. First, professionals can support culturally grounded maternal responsibility practices described by participants, including emotional self-regulation for fetal

protection and wellbeing and spiritual protections, such as avoiding graveyards. Second, professionals can incorporate family as a source of emotional support and as advocates during healthcare encounters when participants feel vulnerable or overwhelmed. Last, care delivery can preserve cultural dignity and privacy, particularly when participants anticipate surveillance or stigma or experience encounters that challenge moral standards. Participants reported that this was often achieved via simple actions, such as being asked about their preferences, being offered alternatives such as a female healthcare professional instead of a male one, or having procedures and policies explained before they began. The core premise of CCT is that wellbeing and health are achieved only when a cultural context is understood, and that culturally congruent care depends on that understanding (McFarland & Wehbe-Alamah, 2019). Alignment with this concept appears through the requirement that culturally rooted health practices, family inclusion in care scenarios, and dignity within healthcare encounters shape maternal wellbeing and support culturally congruent care. This study adds to the existing literature about the application of CCT, demonstrating that cultural preservation functioned as a protective measure against perceived institutional threat: fear of questioning professional authority or of experiencing judgment caused some participants to withhold information about home remedies or cultural practices, save their questions for their maternal family system, and choose silence over potentially negative healthcare encounters.

Cultural Care Accommodation and Negotiation

Positive healthcare encounters as accommodation

Participants described communication as a determining factor in whether a healthcare encounter was perceived as positive or negative. Participants described positive communication as conversations that did not make assumptions about their GRT lifestyle, provided concise information without dwelling on negativity, and remained respectful of their literacy levels. Participants described respectful, positive communication as reducing fear and encouraging engagement, whereas communication perceived as judgmental or professionally dominant heightened stigma and contributed to silence. Within CCT, participants described greater receptivity to compromise regarding healthcare practices when healthcare encounters included respectful, positive communication (Leininger & McFarland, 2006). Therefore, stigma, a primary cause of non-engagement, can be understood as an avoidable outcome of negative healthcare encounters, which can be reduced through positive communication that supports culturally congruent care.

A key goal within CCT is to identify the drivers of culturally congruent care. Previous research has shown that, when communication is examined in isolation, culturally congruent care recognizes cultural expressions and intentionally accommodates them through both language and care delivery (Salinda et al., 2021). Analysis of the interview data revealed that participants became silent and increasingly relied on family members as advocates, while also choosing not to disclose cultural home remedies, when communication with healthcare professionals was rushed, lacked empathy, appeared judgmental, or routinely failed to inquire about the participant's wishes. To accommodate cultural needs and negotiate acceptable care plans, communication must be viewed as

more than mere clarity of language. Culturally congruent communication requires allowing space for questions, validating concerns, and avoiding stereotyping (Leininger & McFarland, 2006). Participants who experienced this type of communication reported more positive healthcare encounters and a sense of emotional safety, leading them to ask questions and share their cultural practices without fear of judgment or stigma.

Flexibility and family

Responses to questions about healthcare encounters, methods for accessing care, and decision-making consistently revealed patterns of service rigidity. These often present as technological difficulties in appointment setting with no alternative, policies that restricted family access, and encounters that did not meet the expectations of care the participant and their family had. Meanwhile, when healthcare professionals demonstrated flexibility, participants recognized their efforts and reported feeling relieved that their flexibility allowed them to have the meaningful healthcare experience they wanted. These accounts demonstrate that small accommodations during routine visits have a significant impact on the participant's overall experience. Flexibility further supports the distinction between barriers to care and conditions of care.

P8 illustrated flexibility during her 20-week scan appointment when she was informed that her large family could not accompany her into the examination room. A compromise was reached when the ultrasound technician explained the reason for this restriction and, as an act of accommodation, agreed to speak with the family afterward in the waiting room and to describe the scan's findings, with the mother's consent. This left the participant feeling respected, and she accepted the compromise because the technician

used positive communication and validated her request as important. When healthcare professionals view disruptions and concerns as understandable reactions that can be accommodated and negotiated, trust and engagement build, placing the act of meeting the conditions of care as a shared responsibility between the participant and the healthcare professional, this aligns with the CCT framework, which views flexibility as an actionable arm of accommodation and negotiation and views service flexibility as an ethical responsibility (Leininger & McFarland, 2006), contrary to the common belief that positive outcomes require the participant being settled and non-transient (Ekezie et al., 2024).

Study participants universally described their healthcare experiences as supported by family inclusion, resulting in feelings of physical and emotional safety and, therefore, viewing family as trusted advocates. When family members were involved in discussions with healthcare professionals by asking them questions and acknowledging their role within the support system, participants reported a positive healthcare experience; P11 noted such an experience when her mother was included in all of the appointments by the dietitian, leading the participant to have a positive outlook on her experience and her gestational diabetes. This account aligns with CCT's framing of family involvement as a meaningful accommodation that should be made in efforts to deliver culturally congruent care, and family involvement should be accommodated as a routine aspect of care rather than an exception (Nascimento et al., 2020). Conditional dignity in CCT is a condition of care that determines the success of negotiation (Leininger & McFarland, 2006).

Participants described respectful treatment as inconsistent and often depending on being known to services, being settled, or appearing compliant. When dignity was thought to be conditional, women described their actions as silent and compliant as a protective strategy. This pattern indicates that accommodation must include explicit reassurance that asking questions or expressing needs will not be punished and that dignity is not contingent on settlement status. In contrast, routine accommodations such as plain-language explanations, information presented in manageable stages, permission to ask questions, and flexibility may significantly affect an individual's perceived safety and engagement.

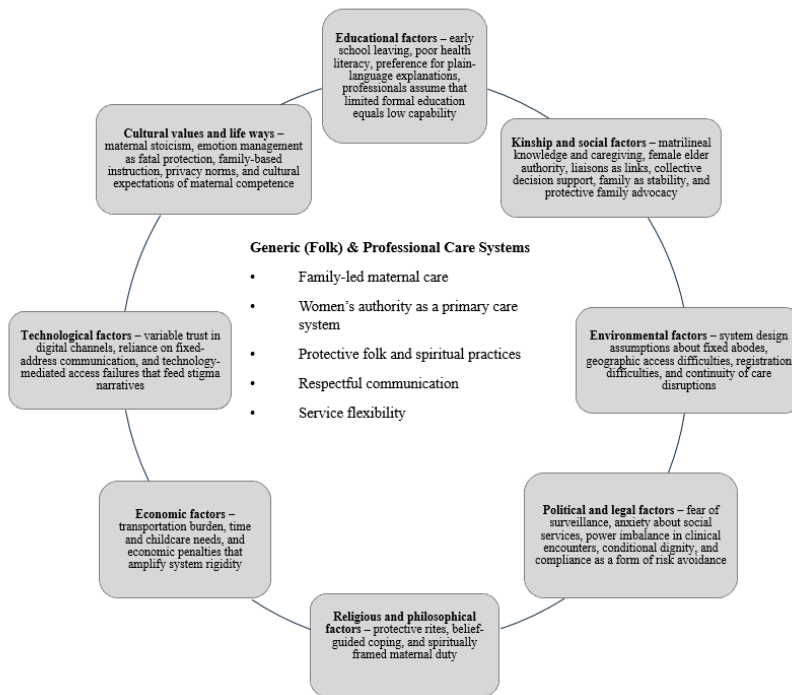
Sunrise Enabler Model

The Sunrise Enabler Model is a method for mapping social and cultural forces can show how people understand, define, and experience culture. Leininger's Sunrise Enabler supports culturally congruent care by organizing these forces into interacting domains: kinship, cultural values, religion, politics, economics, education, environment, and technology, as viewed through a folk care lens (McFarland & Wehbe-Alamah, 2019). Clinicians can use the model to understand the influences on care decisions and actions, allowing them to respond with the appropriate preservation/maintenance or accommodation/negotiation approaches. The interview guide used in this study directly aligned with the Sunrise Enabler domains (See Appendix D, Table 4), and questions assigned to each domain ensured that participant's accounts addressed each domain in culturally grounded terms, rather than culture as an additional variable. Within the Sunrise Enabler Model, culture is described as inextricably linked to forces that affect

health (McFarland & Wehbe-Alamah, 2019). When considered together, the Sunrise Enabler domains yield a holistic view of GRT maternal health as a set of health beliefs and practices shaped by family authority structures, learned expectations of maternal responsibility, stigma management practices, and ongoing negotiation with institutions.

This work aimed to develop a Sunrise Enabler Model that reflected GRT maternal health systems described by participants. The question mapping in Appendix D clarified which participant answers belonged to each Sunrise Enabler domain, and the coded responses grouped into themes provided context for understanding how the domains interacted in real maternal care experiences. This approach produced a model that moves beyond identifying SDoH or detailing barriers to access in isolation. Participants described both barriers to access, such as communication failures and system assumptions about settlement, as well as conditions of care once access occurred, such as conditional dignity and surveillance fear. The distinction is vital in practice, as improving access without addressing conditions of care risks furthering health inequities. Using this GRT maternal health specific model gives healthcare professionals a tool to identify both barriers to access and conditions of care, and to provide culturally congruent care. The full illustrative model is shown in Figure 2 with an explanation of each factor provided in the text that follows.

Figure 2

GRT Maternal Health Sunrise Enabler Model

Note. Adapted from “Leininger’s Theory of Culture Care Diversity and Universality: an overview with a historical retrospective and a view toward the future,” by M. McFarland, and H. Wehbe-Alamah, 2019, *Journal of Transcultural Nursing*, 30(6), p. 540-557 (<https://doi.org/10.1177/1043659619867134>).

Kinship and Social Factors

Kinship and social factors were discovered with questions addressing who supports the participant during pregnancy and birth, and how family roles shape care decisions. Participants explained family as the first and preferred maternal care system. Theme 1 (Women as the Primary Care System) highlighted how the participants relied on

female relatives for knowledge and advice, emotional and physical support, and decision making. Examining the responses reveals maternal responsibility as culturally learned and collectively enforced through kin networks. Rather than viewing family presence at healthcare encounters as a preference, participants explained it as a necessary protective structure that supports physical and emotional wellbeing.

This finding adds to the broader literature on GRT communities, which often identifies strong family networks (Condon et al., 2019) but does not examine or acknowledge how kinship functions as a care system during maternal healthcare. This study identified the following kinship factors: matrilineal knowledge and caregiving, female elder authority, liaisons as links, collective decision support, family as stability, and protective family advocacy during appointments. These factors describe how the GRT woman experienced family support and how they interpreted professional advice.

Cultural Values and Lifeways

Cultural values and lifeways, the day-to-day patterns of life specific to the culture (McFarland & Wehbe-Alamah, 2019), were identified through questions about cultural expectations during pregnancy, beliefs about what makes a good mother, and detailing practices that protect the baby. Participants defined maternal health in terms of culturally grounded responsibilities as opposed to clinical outcomes. Theme 2 (Cultural Definitions of Maternal Health and Responsibility) provided the definition of maternal health as the mother's ability to maintain calm and avoid stress, as well as uphold behaviors believed to physically and spiritually protect the baby. Participants explained emotional regulation as a required duty for the mother and not simply a wellness aspiration, and the calmness

that participants explained as essential is a culturally instructed requirement that is directly connected to fetal outcomes. This finding adds to GRT maternal health literature by illustrating how cultural values translate into maternal practices, particularly when women purposefully manage stress and limit specific physical activities to reduce perceived risks to the baby. The study identified the following cultural values and lifeways: maternal stoicism, emotion management as fetal protection, family-based instruction, privacy norms, and cultural expectations of maternal competence. These values shaped communication with professionals, allowed for a willingness to disclose concerns, and culturally defined what a good mother was.

Religious and Philosophical Factors

Religious and philosophical factors were identified through questions about folk-based (cultural) spirituality and religious practices that focused on how belief systems guide pregnancy behaviors. Participants described spiritual practices that are deeply rooted in cultural beliefs as vital components of maternal responsibility, particularly during times of uncertainty and vulnerability. Rather than presenting spirituality as separate from care, participants described it as integrated into protective action, such as when women felt a lack of control within professional systems. This finding supports the need for maternal care models that recognize folk-based spiritual and religious practices as part of a culturally meaningful protection method, rather than treating them as unrelated to health. The study identified the following religious and philosophical factors: protective rites, belief-guided coping, and spiritually framed maternal duty. The study's

findings demonstrated that these factors can coexist with clinical care when professionals respond with respect and non-judgment.

Technological Factors

Technological factors were identified through questions about digital communication methods and technology use. The questions focused on barriers created by digital health systems and technology use patterns. The study's recruitment difficulties demonstrated that social media outreach failed despite a known online GRT presence, whereas recruitment succeeded through trusted liaison relationships. Despite some known use of technology, participants voiced mistrust about it due to privacy concerns when sharing personal information online. The conditions that appear to dictate technology use highlight a key distinction: technology may exist, but trust determines if GRT women will use it for health-related engagement or research. Participants' accounts of digital healthcare engagement indicated that systems that rely on standardized digital communication and fixed-address assumptions often create exclusion. As a result, GRT women experience judgment or are labeled non-compliant by staff tasked with engaging with the population. The study identified the following technological factors: variable trust in digital channels, reliance on fixed-address communication, and technology-mediated access failures that feed stigma narratives.

Educational Factors

Educational factors were identified through questions about education level, understanding of written care information, and how the women interpreted and processed medical language. The study found limited formal education within the study's

participant pool, with no participants reporting Sixth Form attendance and a small number completing secondary school. These findings help professionals navigate health encounters, as education is a core component of health system communication standards which assumes a basic level of literacy. When services rely on written materials, fast-paced verbal instruction, and medical jargon-heavy explanations, the burden shifts onto women to understand systems while simultaneously managing stigma risk. The study identified the following educational factors: early school leaving, health literacy shaped by maternal-led home-based learning, a preference for plain-language explanations, and the risk of stigma when professionals assume that limited formal education equals low capability.

Economic Factors

Economic factors were identified through questions about practical economic barriers to establishing and maintaining healthcare engagement. Participants did not describe maternity care in terms of economic problems and pressures; however, economic factors interacted with mobility, scheduling, and appointment compliance pressures stemming from missed-appointment penalties. Missed appointments often resulted from a lack of transportation, reliance on public buses, caregiving demands, or inflexible appointment scheduling, rather than an unwillingness to engage. The study identified the following economic factors: transportation burden, time and childcare needs, and economic penalties that amplify system rigidity.

Political and Legal Factors

Political and legal factors were identified through questions about experiences within the healthcare system, specifically patient rights and professional authority. Participants described maternal care experiences shaped by fear of surveillance and perceived judgment, and the stigma that follows. Theme 4 (Surveillance, Stigma, and Conditional Dignity) documented how anticipatory stigma led many women to remain silent, avoid questioning authority, and comply as a protective strategy. This fear was described by P2 when recalling a family member who had their children temporarily removed from their care, and the fear that saying the wrong thing could cause the same thing to happen to her. Participants explained silence and compliance as learned ways of managing professional authority and power imbalances. Family systems taught and encouraged these strategies to ensure personal and family safety. The study identified the following political and legal factors: fear of surveillance, anxiety about social services, power imbalance in clinical encounters, conditional dignity, and compliance as a form of risk avoidance. The findings from this specific factor echo the larger study's conclusions in that care pathways should result in dignity regardless of settlement status.

Environmental Factors

Environmental factors were identified through questions about mobility, housing, and service geography. Theme 5 (Mobility and Settlement) showed that mobility influenced participants' experiences attending appointments. Meanwhile, service providers often held negative assumptions about mobility, leading to settlement as a frequently recommended remedy. Analyzing the environmental factors alongside the

other Sunrise Enabler factors demonstrates that settlement itself did not resolve the conditions of care associated with stigma, fear of surveillance, and a sense of dignity that depends on compliance. Instead, trust and engagement were strengthened when professionals acted with respect and demonstrated a willingness to negotiate, even where women's residences were unstable. The study identified the following environmental factors: system design assumptions about fixed abodes, geographic access difficulties, registration difficulties, and continuity of care disruptions.

Generic (Folk) and Professional Care Systems

Folk (generic) and professional care system factors were identified through questions about culturally rooted practices used during pregnancy, as well as how women sought advice, reassurance, and protection. In the Sunrise Enabler, generic care is defined as care practices originating from family and culture that function alongside professional care systems to support the delivery of culturally congruent care (McFarland & Wehbe-Alamah, 2019). Participants described a functioning generic care system grounded in family knowledge, women's authority, and protective practices. Theme 1 placed women as the primary care system, and Theme 2 showed how maternal health was monitored through culturally expected behaviors. Taken together, the analysis of these themes support treating generic care as a legitimate and vital component of GRT maternal health, rather than dismissing it as misinformation or invalid. Professional care functions as a parallel system of care accessed through NHS maternity services but is often experienced through negotiation, risk management, and power imbalance (Themes 3 and 4). Participants did not describe professional care as unnecessary or dismiss its importance.

Rather, when recalling positive encounters, they described respectful communication, service flexibility, and meaningful inclusion of family members as factors that improved encounters and supported engagement. A clinical care model treats maternal care as a lived framework combining generic and professional care. The analysis identified the following factors within the generic and professional care systems: family-led maternal care and women's authority as a primary care system; protective folk and spiritual practices; respectful communication that enables negotiation; and service flexibility, including willingness to compromise.

Limitations of the Study

Though this study achieved its goals, it is not without its limitations. Notably, this is evidenced in the recruitment and the participant pool it created, as well as in the transferability of the findings. The intended recruitment method included social media outreach, with structured GRT outreach organizations used if necessary. Social media recruitment failed, but a local GRT liaison group distributed the study flyer to community members, resulting in several successful participant sign-ups. The intended snowball sampling was successful, with the first wave of participants recommending other GRT family members and friends. The success of the purposive and snowball sampling methods relied on trust from the liaisons and the first wave of participants (Palinkas et al., 2015). However, this process created an important limitation of the study.

The study participant pool reflects only participants who were willing to engage with services, as evidenced by their working relationship with the liaisons, or were family or friends of those who did. The recruitment method linked participants who shared

similar geography or experiences, as indicated by their kinship. This can result in an echo chamber in which beliefs and actions appear more significant due to their repeated appearance in participant interviews (Wang et al., 2024). This limitation must be taken into account when considering transferability. The study design explicitly states that a focused ethnographic approach guided the study; therefore, the findings are culturally bound and further restrained by the limited participant pool. A focused ethnographic study focuses on a specific phenomenon, viewing it within the unique environment of the culture being studied, rather than on a population-wide generalization (Black et al., 2021; Trundle & Phillips, 2023). While the study design limits transferability, it is an asset for culture-specific research.

The CCT has three distinct domains: preservation/maintenance, accommodation/negotiation, and repatterning/restructuring. Repatterning and restructuring involve changing health behaviors, adapting how care is applied, and tracking outcomes (Leininger & McFarland, 2006). As this was a focused ethnographic study, interviews focused solely on GRT women and did not include data from healthcare practitioners. This could be viewed as a limitation in that it does not reflect how care is experienced from the professional perspective; however, that was not the purpose of this study.

Recommendations

The recommendations describe the applicability of culturally congruent care and build on the results of the analysis. The analysis identified specific factors shaping GRT maternal healthcare, and the primary recommendation is adoption of the Sunrise Enabler

Model as a clinical tool for delivering culturally congruent care. The model can be further researched and expanded into other health domains known to have concerning outcomes for the GRT population, such as immunizations, child health, and mental health (McFadden et al., 2017; Mytton et al., 2020). Adoption of such models supports the adoption and standardization of culturally congruent care across geographic regions or systems wide.

A commonly expressed concern among participants was their desire for healthcare professionals to understand GRT culture. While cultural competency training for healthcare professionals alone does not result in a positive experience for GRT women (Morgan & Belenky, 2024), when used in conjunction with culturally congruent care, it could encourage healthcare encounters without stigma or judgment. In addition to workforce development, the Sunrise Enabler provides further areas for recommendations, including health-literate appropriate communications and office policies that support preservation/maintenance and accommodation/negotiation skills. Adopting a culturally congruent care model is a future recommendation, as a longitudinal study could yield significant research findings by following GRT participants across their pregnancies and tracking how negotiated encounters evolve with trust and culturally congruent care, with the potential to yield both qualitative and quantitative outcomes.

Implications

The findings of this study have important public health and clinical delivery implications, resulting in positive social change and methodical procedures. Positive social change is possible through the use of the Sunrise Enabler as a clinical tool. The

findings demonstrate that the health of marginalized populations should be viewed through a condition of care lens, not a barrier to access lens. When identifying conditions of care meaningful to the GRT population for maternal health, accommodation and negotiation provide the mechanism to deliver culturally congruent care (McFarland & Wehbe-Alamah, 2019). Identifying and acting on the factors that enable accommodation and negotiation is possible because cultural values, kinship structures, environmental constraints, and institutional policies that shape engagement are identifiable through the Sunrise Enabler Model (Leininger & McFarland, 2006; McFarland & Wehbe-Alamah, 2019). Adoption of this model supports increased engagement at the individual level, promotes compliance at the organizational level, and addresses equity concerns at the national level.

Conducting this study highlighted structural implications that could prove helpful for future researchers. The use of liaisons for recruitment was directly responsible for the success of this study, introducing a known and trusted element that provided a culturally safe recruitment mechanism and increased participation. While the sampling limitations have been discussed, they could be mitigated by planning for them in the study design. Liaisons also highlight the potential for research to facilitate co-production with the GRT community. Co-production, particularly with marginalized populations, provides a place for participants' voices to be heard and encourages engagement (Dunn et al., 2024). Therefore, this study adds to the knowledge base on best practices for conducting research with the GRT population.

Conclusion

The analysis identified five themes that answered the research questions and provided the basis for development of a GRT maternal health Sunrise Enabler model. This focused ethnographic study found that GRT women who received maternal care through the NHS in the United Kingdom described care as relational and shaped by how well it accommodates cultural traditions and family expectations. Participants defined maternal health as a period of maternal responsibility that requires physical and emotional regulation and regularly incorporates folk beliefs. Family was described as the primary care system, led by older female generations. Maternal health was therefore defined and experienced as a cultural practice grounded in kinship and tradition, with clinical encounters forming one part of the experience rather than the organizing structure.

This study is timely and vital. Despite a socialized healthcare system in the United Kingdom, compared to non-GRT women, GRT women face a shortened life expectancy, increased miscarriages, and societal discrimination and stigma (Friends, Families & Travellers, 2022). The findings show that improving maternal care requires more than simply access. Maternal care for the GRT population requires conditions of care in which dignity is consistent, communication is respectful, family involvement is supported, and negotiation is possible without fear. Increasing engagement as a pathway to better outcomes can be achieved through culturally congruent care. The GRT population is rich in history and tradition, values family, and participants placed their children's health above all else. This population should be treated with dignity and respect regardless of

education or mobility. Practicing culturally congruent care, as identified in this study's findings and operationalized through the Sunrise Enabler model, provides a clear pathway for improving maternal care and reducing inequities.

References

- Adley, M., Alderson, H., Jackson, K., McGovern, W., Spencer, L., Addison, M., & O'Donnell, A. (2023). Ethical and practical considerations for including marginalised groups in quantitative survey research. *International Journal of Social Research Methodology*, 27(5), 559–574.
<https://doi.org/10.1080/13645579.2023.2228600>
- Agner, J. (2020). Moving from cultural competence to cultural humility in Occupational therapy: a paradigm shift. *American Journal of Occupational Therapy*, 74(4), 7404347010p1-7404347010p7. <https://doi.org/10.5014/ajot.2020.038067>
- Ahmed, S. K. (2024). The pillars of trustworthiness in Qualitative research. *SSRN Electronic Journal*. <https://doi.org/10.2139/ssrn.4965351>
- Ares, T. L. (2021). American Roma: A cultural care case study. *Journal of Transcultural Nursing*, 32(2), 111–118. <https://doi.org/10.1177/1043659619899995>
- Black, G. B., Van Os, S., Machen, S., & Fulop, N. J. (2021). Ethnographic research as an evolving method for supporting healthcare improvement skills: a scoping review. *BMC Medical Research Methodology*, 21(1). <https://doi.org/10.1186/s12874-021-01466-9>
- Booth, A., Carroll, C., Ilott, I., Low, L. L., & Cooper, K. (2012). Desperately seeking dissonance. *Qualitative Health Research*, 23(1), 126–141.
<https://doi.org/10.1177/1049732312466295>
- Chinoporou, C., Diamanti, A., Asimaki, E., Nanou, C., Varela, P., Vivilaki, V., & Deltsidou, A. (2025). Cultural competence of Obstetricians/Gynecologists and

midwives providing midwifery care to Roma women in Western Greece.

Healthcare, 13(2), 190. <https://doi.org/10.3390/healthcare13020190>

Claisse, C., Durrant, A. C., & Lie, M. (2024). Understanding antenatal care needs through Co-Creation with Roma Women to inform the design of MHealth technologies. *CHI '24: Proceedings of the 2024 CHI Conference on Human Factors in Computing Systems*, 531, 1–16.

<https://doi.org/10.1145/3613904.3642584>

Condon, L., Bedford, H., Ireland, L., Kerr, S., Mytton, J., Richardson, Z., & Jackson, C.

(2019). Engaging Gypsy, Roma, and Traveller communities in research: maximizing opportunities and overcoming challenges. *Qualitative Health Research*, 29(9), 1324–1333. <https://doi.org/10.1177/1049732318813558>

Condon, L., Curejova, J., Morgan, D. L., Miles, G., & Fenlon, D. (2021). Knowledge and experience of cancer prevention and screening among Gypsies, Roma and Travellers: a participatory qualitative study. *BMC Public Health*, 21(1).

<https://doi.org/10.1186/s12889-021-10390-y>

Condon, L., Hargreaves, S. C., Barry, D., Curejova, J., Morgan, D. L., Worrall, S., Celik, F., & Price, M. (2024). Experiences of Alcohol Use and Harm among Travellers, Roma, and Gypsies: A Participatory Qualitative Study. *Health & Social Care in the Community*, 2024, 1–10. <https://doi.org/10.1155/2024/9020329>

Crear-Perry, J., Correa-De-Araujo, R., Johnson, T. L., McLemore, M. R., Neilson, E., & Wallace, M. (2020). Social and structural determinants of health inequities in

maternal health. *Journal of Women S Health*, 30(2), 230–235.

<https://doi.org/10.1089/jwh.2020.8882>

Dahal, N., Neupane, B. P., Pant, B. P., Dhakal, R. K., Giri, D. R., Ghimire, P. R., & Bhandari, L. P. (2024). Participant selection procedures in qualitative research: experiences and some points for consideration. *Frontiers in Research Metrics and Analytics*, 9. <https://doi.org/10.3389/frma.2024.1512747>

Danvers, E., & Hinton-Smith, T. (2024). Marginalisation and mixed feelings: supporting students of Gypsy, Roma and traveller heritage imagining higher education in the UK. *Compare a Journal of Comparative and International Education*, 54(3), 518–535. <https://doi.org/10.1080/03057925.2022.2129959>

De Oliveira Tavares, E. A., & Ramos, M. N. (2023). Cultural influence on Angolan maternal care of newborns and health strategies: health professionals' perspective. *Research Society and Development*, 12(4), e9612441039. <https://doi.org/10.33448/rsd-v12i4.41039>

Diguisto, C., Saucedo, M., Kallianidis, A., Bloemenkamp, K., Bødker, B., Buoncristiano, M., Donati, S., Gissler, M., Johansen, M., Knight, M., Korbel, M., Kristufkova, A., Nyflot, L. T., & Deneux-Tharoux, C. (2022). Maternal mortality in eight European countries with enhanced surveillance systems: descriptive population based study. *BMJ*, e070621. <https://doi.org/10.1136/bmj-2022-070621>

Dunn, M., Turner-Moss, E. J. C., Carpenter, B., Speed, E., Dixon, K. C., & Blumenfeld, T. (2024). The effects of literacy on health in Gypsies, Roma and Travellers

- (GRT): a systematic review and narrative synthesis. *BMJ Global Health*, 9(11), e017277. <https://doi.org/10.1136/bmjgh-2024-017277>
- Ekezie, W., Cassambai, S., Czyznikowska, B., Curtis, F., O'Mahoney, L. L., Willis, A., Chudasama, Y., Khunti, K., & Farooqi, A. (2023). Health and social care experience and research perception of different ethnic minority populations in the East Midlands, United Kingdom (REPRESENT study). *Health Expectations*, 27(1). <https://doi.org/10.1111/hex.13944>
- Ekezie, W., Hopwood, E., Czyznikowska, B., Weidman, S., Mackintosh, N., & Curtis, F. (2024). Perinatal health outcomes of women from Gypsy, Roma and Traveller communities: A systematic review. *Midwifery*, 129, 103910. <https://doi.org/10.1016/j.midw.2023.103910>
- Ellis, N., Walker-Todd, E., & Heffernan, C. (2020). Influences on childhood immunisation decision-making in London's Gypsy and Traveller communities. *British Journal of Nursing*, 29(14), 822–823. <https://doi.org/10.12968/bjon.2020.29.14.822>
- Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis. *SAGE Open*, 4(1). <https://doi.org/10.1177/2158244014522633>
- Fair, F., Raben, L., Watson, H., Vivilaki, V., Van Den Muijsenbergh, M., & Soltani, H. (2020). Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: A systematic review. *PLoS ONE*, 15(2), e0228378. <https://doi.org/10.1371/journal.pone.0228378>

- Fletcher, F. E., Rice, W. S., Ingram, L. A., & Fisher, C. B. (2019). Ethical Challenges and Lessons Learned from Qualitative Research with Low-Income African American Women Living with HIV in the South. *Journal of Health Care for the Poor and Underserved*, 30(4S), 116–129. <https://doi.org/10.1353/hpu.2019.0122>
- Frantz, P., Rego, F., & Barbas, S. (2025). Reclaiming human dignity: a critical review of contemporary theories in light of ontological foundations. *Medicine Health Care and Philosophy*, 28(4), 791–797. <https://doi.org/10.1007/s11019-025-10290-7>
- Friends, Families & Travellers. (2022). *Briefing: Health Inequalities experienced by Gypsy, Roma and Traveller communities*. https://www.gypsy-traveller.org/wp-content/uploads/2022/11/Briefing_Health-inequalities-experienced-by-Gypsies-and-Travellers-in-England.pdf
- Gertner, A. K., Franklin, J., Roth, I., Cruden, G. H., Haley, A. D., Finley, E. P., Hamilton, A. B., Palinkas, L. A., & Powell, B. J. (2021). A scoping review of the use of ethnographic approaches in implementation research and recommendations for reporting. *Implementation Research and Practice*, 2. <https://doi.org/10.1177/2633489521992743>
- Goyal, D., & Selix, N. W. (2021). Impact of COVID-19 on maternal mental health. *MCN the American Journal of Maternal/Child Nursing*, 46(2), 103–109. <https://doi.org/10.1097/nmc.0000000000000692>

- Guest, G., Namey, E., & Chen, M. (2020). A simple method to assess and report thematic saturation in qualitative research. *PLoS ONE*, *15*(5), e0232076.
<https://doi.org/10.1371/journal.pone.0232076>
- Hamal, M., Dieleman, M., De Brouwere, V., & De Cock Buning, T. (2020). Social determinants of maternal health: a scoping review of factors influencing maternal mortality and maternal health service use in India. *Public Health Reviews*, *41*(1).
<https://doi.org/10.1186/s40985-020-00125-6>
- Heaslip, V., Wilson, D., & Jackson, D. (2019). Are Gypsy Roma Traveller communities indigenous and would identification as such better address their public health needs? *Public Health*, *176*, 43–49. <https://doi.org/10.1016/j.puhe.2019.02.020>
- Heiskanen, J., MacKay, J., Neumann, I. B., Wigen, E., Eskild, I., Hall, M., Engelhard, A., Owens, H., Levin, J., & Kappes, F. (2024). Nomads and international relations: post-sedentarist dialogues. *Cambridge Review of International Affairs*, 1–35.
<https://doi.org/10.1080/09557571.2024.2426782>
- Hennink, M. M., Kaiser, B. N., & Marconi, V. C. (2016). Code saturation versus meaning saturation. *Qualitative Health Research*, *27*(4), 591–608.
<https://doi.org/10.1177/1049732316665344>
- Herwansyah, H., Czabanowska, K., Kalaitzi, S., & Schröder-Bäck, P. (2022). The utilization of maternal health services at primary healthcare setting in Southeast Asian Countries: A systematic review of the literature. *Sexual & Reproductive Healthcare*, *32*, 100726. <https://doi.org/10.1016/j.srhc.2022.100726>

- Hoang, T. H., & Wong, A. (2023). Exploring the Application of Intersectionality as a Path toward Equity in Perinatal Health: A Scoping Review. *International Journal of Environmental Research and Public Health*, 20(1), 685.
<https://doi.org/10.3390/ijerph20010685>
- Holman, D., Salway, S., Bell, A., Beach, B., Adebajo, A., Ali, N., & Butt, J. (2021). Can intersectionality help with understanding and tackling health inequalities? Perspectives of professional stakeholders. *Health Research Policy and Systems*, 19(1). <https://doi.org/10.1186/s12961-021-00742-w>
- Jager, K. J., Tripepi, G., Chesnaye, N. C., Dekker, F. W., Zoccali, C., & Stel, V. S. (2020). Where to look for the most frequent biases? *Nephrology*, 25(6), 435–441.
<https://doi.org/10.1111/nep.13706>
- Jones, G. L., Mitchell, C. A., Hirst, J. E., & Anumba, D. O. (2022). Understanding the relationship between social determinants of health and maternal mortality. *BJOG an International Journal of Obstetrics & Gynaecology*, 129(7), 1211–1228.
<https://doi.org/10.1111/1471-0528.17044>
- Jones, J., & Smith, J. (2017). Ethnography: challenges and opportunities. *Evidence-Based Nursing*, 20(4), 98–100. <https://doi.org/10.1136/eb-2017-102786>
- Khan, Z., Vowles, Z., Turienzo, C. F., Barry, Z., Brigante, L., Downe, S., Easter, A., Harding, S., McFadden, A., Montgomery, E., Page, L., Rayment-Jones, H., Renfrew, M., Silverio, S. A., Spiby, H., Villarroel-Williams, N., & Sandall, J. (2023). Targeted health and social care interventions for women and infants who are disproportionately impacted by health inequalities in high-income countries: a

systematic review. *International Journal for Equity in Health*, 22(1).

<https://doi.org/10.1186/s12939-023-01948-w>

Kothari, R., Ward, A., & Tracy, D. (2024). Gypsy, Roma and Traveller populations and mental health in the UK: a need for real working together and co-production of services. *BJPsych International*, 21(3), 66–69. <https://doi.org/10.1192/bji.2024.14>

Leininger, M. (1991). *Culture Care Diversity and Universality: A Theory of Nursing*.

Jones and Bartlett Publishers, Inc. <https://ci.nii.ac.jp/ncid/BA52979788>

Leininger, M. M., & McFarland, M. R. (2006). Culture care diversity and universality : a worldwide nursing theory. In *Jones and Bartlett eBooks* (2nd ed.).

<http://ci.nii.ac.jp/ncid/BA79924856>

Lim, W. M. (2024). What is qualitative research? An overview and guidelines.

Australasian Marketing Journal (AMJ).

<https://doi.org/10.1177/14413582241264619>

MacGregor, B., Shakespeare, J., Kotnis, R., Knight, M., & Hillman, S. (2022).

MBRRACE 2021: preventing maternal deaths — we are all part of the solution.

British Journal of General Practice, 72(717), 148–149.

<https://doi.org/10.3399/bjgp22x718829>

MBRRACE-UK. (2024). *Saving Lives, Improving Mothers' Care 2024 - Lessons*

Learned to Inform Maternity Care from the UK and Ireland Confidential

Enquiries into Maternal Deaths and Morbidity 2020-22. The National Perinatal

Epidemiology Unit. [https://www.npeu.ox.ac.uk/mbrance-uk/reports/maternal-](https://www.npeu.ox.ac.uk/mbrance-uk/reports/maternal-reports/maternal-report-2020-2022)

[reports/maternal-report-2020-2022](https://www.npeu.ox.ac.uk/mbrance-uk/reports/maternal-reports/maternal-report-2020-2022)

- McFadden, A., Siebelt, L., Gavine, A., Atkin, K., Bell, K., Innes, N., Jones, H., Jackson, C., Haggi, H., & MacGillivray, S. (2017). Gypsy, Roma and Traveller access to and engagement with health services: a systematic review. *European Journal of Public Health*, 28(1), 74–81. <https://doi.org/10.1093/eurpub/ckx226>
- McFarland, M. R., & Wehbe-Alamah, H. B. (2019). Leininger's Theory of Culture Care Diversity and Universality: an overview with a historical retrospective and a view toward the future. *Journal of Transcultural Nursing*, 30(6), 540–557. <https://doi.org/10.1177/1043659619867134>
- McKinney, J. L. G., & Meinersmann, L. M. (2022). The cost of intersectionality: Motherhood, mental health, and the state of the country. *Journal of Social Issues*, 79(2), 596–616. <https://doi.org/10.1111/josi.12539>
- Montreuil, M., Bogossian, A., Laberge-Perrault, E., & Racine, E. (2021). A review of approaches, strategies and ethical considerations in participatory research with children. *International Journal of Qualitative Methods*, 20. <https://doi.org/10.1177/1609406920987962>
- Morgan, J., & Belenky, N. (2024). Exploring health inequalities in Gypsy and Traveller communities in the UK. *Nursing Standard*, 39(10), 69–73. <https://doi.org/10.7748/ns.2024.e12285>
- Myatra, S. N., Tripathy, S., & Einav, S. (2021). Global health inequality and women – beyond maternal health. *Anaesthesia*, 76(S4), 6–9. <https://doi.org/10.1111/anae.15431>

- Mytton, J., Bedford, H., Condon, L., & Jackson, C. (2020). Improving immunization uptake rates among Gypsies, Roma and Travellers: a qualitative study of the views of service providers. *Journal of Public Health, 43*(4), e675–e683.
<https://doi.org/10.1093/pubmed/fdaa100>
- Naeem, M., Ozuem, W., Howell, K., & Ranfagni, S. (2023). A Step-by-Step process of thematic analysis to develop a conceptual model in qualitative research. *International Journal of Qualitative Methods, 22*.
<https://doi.org/10.1177/16094069231205789>
- Nascimento, A. C. S. T., Morais, A. C., Da Cruz Amorim, R., & Santos, D. V. D. (2020). The care provided by the family to the premature newborn: analysis under Leininger's Transcultural Theory. *Revista Brasileira De Enfermagem, 73*(suppl 4). <https://doi.org/10.1590/0034-7167-2019-0644>
- NHS (n.d.). *Your antenatal care*. nhs.uk. <https://www.nhs.uk/pregnancy/your-pregnancy-care/your-antenatal-care/>
- NHS England. (2023). *Safeguarding*. <https://www.england.nhs.uk/long-read/safeguarding/>
- NHS Race and Health Observatory. (2023). Progress Report 2022-2023. In *NHS Race and Health Observatory*.
- Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis. *International Journal of Qualitative Methods, 16*(1).
<https://doi.org/10.1177/1609406917733847>

- O'Brien, M., Dempsey, B., & Higgins, M. (2022). Experiences and outcomes of Gypsy, Roma and Traveller women in pregnancy: a scoping review protocol. *BMJ Open*, *12*(7), e057788. <https://doi.org/10.1136/bmjopen-2021-057788>
- OECD. (2019). *State of Health in the EU United Kingdom: Country Health Profile 2019*. OECD Publishing.
- Office for National Statistics. (2022, December 7). *Gypsies' and travellers' lived experiences, health, England and Wales*. <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/gypsiesandtravellerslivedexperienceshealthenglandandwales/2022>
- Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*(5), 533–544. <https://doi.org/10.1007/s10488-013-0528-y>
- Pavlikova, B., Freel, L., & Van Dijk, J. P. (2020). To comply or not to comply: Roma approach to health laws. *International Journal of Environmental Research and Public Health*, *17*(9), 3087. <https://doi.org/10.3390/ijerph17093087>
- QSR International. (n.d.). *NVivo 11 for Windows help - Using NVivo for qualitative research*. https://help-nv11.qsrinternational.com/desktop/concepts/using_nvivo_for_qualitative_research.htm

- Reyes, V., Bogumil, E., & Welch, L. E. (2021). The Living Codebook: Documenting the process of Qualitative Data analysis. *Sociological Methods & Research*, 53(1), 89–120. <https://doi.org/10.1177/0049124120986185>
- Rutakumwa, R., Mugisha, J. O., Bernays, S., Kabunga, E., Tumwekwase, G., Mbonye, M., & Seeley, J. (2019). Conducting in-depth interviews with and without voice recorders: a comparative analysis. *Qualitative Research*, 20(5), 565–581. <https://doi.org/10.1177/1468794119884806>
- Ryan, G. S. (2017). An introduction to the origins, history and principles of ethnography. *Nurse Researcher*, 24(4), 15–21. <https://doi.org/10.7748/nr.2017.e1470>
- Saldaña J. (2021). *The Coding Manual for Qualitative Researchers*. Sage Publications Limited.
- Salinda, M. T., Hipona, J. B., Ilarde, M., & Tuazon, A. (2021). A concept analysis on culturally congruent care. *Journal of Nursing Practice*, 4(2), 167–176. <https://doi.org/10.30994/jnp.v4i2.132>
- Sarafian, I., Robinson, A., Christov, A., & Tarchini, A. (2024). In the margins of stigma: health inequalities among Bulgarian Roma in a post-COVID-19 UK. *BMJ Global Health*, 9(11), e015686. <https://doi.org/10.1136/bmjgh-2024-015686>
- Silverio, S. A., Varman, N., Barry, Z., Khazaezadeh, N., Rajasingam, D., Magee, L. A., & Matthew, J. (2023). Inside the ‘imperfect mosaic’: Minority ethnic women’s qualitative experiences of race and ethnicity during pregnancy, childbirth, and maternity care in the United Kingdom. *BMC Public Health*, 23(1). <https://doi.org/10.1186/s12889-023-17505-7>

- Stalmeijer, R. E., Brown, M. E. L., & O'Brien, B. C. (2024). How to discuss transferability of qualitative research in health professions education. *The Clinical Teacher*, 21(6). <https://doi.org/10.1111/tct.13762>
- Stenfors, T., Kajamaa, A., & Bennett, D. (2020). How to . . . assess the quality of qualitative research. *The Clinical Teacher*, 17(6), 596–599. <https://doi.org/10.1111/tct.13242>
- Suffolk County Council. (2023). *Gypsy, Roma, and Traveller communities in Suffolk health needs assessment*.
- Sutton, J., & Austin, Z. (2015). Qualitative research: data collection, analysis, and management. *The Canadian Journal of Hospital Pharmacy*, 68(3). <https://doi.org/10.4212/cjhp.v68i3.1456>
- Taylor, B., & Hinks, J. (2021). What field? Where? Bringing Gypsy, Roma and Traveller history into view. *Cultural and Social History*, 18(5), 629–650. <https://doi.org/10.1080/14780038.2021.1960552>
- The Commonwealth Fund. (2025). International Health Care System Profiles. <https://www.commonwealthfund.org/international-health-policy-center/countries/england>
- Thomson, G., Cook, J., Crossland, N., Balaam, M., Byrom, A., Jassat, R., & Gerrard, S. (2022). Minoritised ethnic women's experiences of inequities and discrimination in maternity services in North-West England: a mixed-methods study. *BMC Pregnancy and Childbirth*, 22(1). <https://doi.org/10.1186/s12884-022-05279-6>

- Townsend, L., Salemink, K., & Wallace, C. D. (2020). Gypsy–Traveller communities in the United Kingdom and the Netherlands: socially and digitally excluded? *Media Culture & Society*, 42(5), 637–653. <https://doi.org/10.1177/0163443718807381>
- Trundle, C., & Phillips, T. (2023). Defining focused ethnography: Disciplinary boundary-work and the imagined divisions between ‘focused’ and ‘traditional’ ethnography in health research – A critical review. *Social Science & Medicine*, 332, 116108. <https://doi.org/10.1016/j.socscimed.2023.116108>
- Ugwu, C. (2017). History of ethnography: Straitening the records. *International Journal of Sociology and Anthropology*, 9(7), 64–68. <https://doi.org/10.5897/ijasa2016.0670>
- UK Gov. (2024, October 30). *National minimum wage and national living wage rates*. GOV.UK. <https://www.gov.uk/national-minimum-wage-rates>
- UK Government. (2022). *Gypsy, Roma and Irish Traveller ethnicity summary*. GOV.UK Ethnicity Facts And Figures. <https://www.ethnicity-facts-figures.service.gov.uk/summaries/gypsy-roma-irish-traveller/>
- UK Government. (2025, February 3). *The national curriculum*. GOV.UK. <https://www.gov.uk/national-curriculum/overview>
- UK Parliament. (2019). *Tackling inequalities faced by Gypsy, roma and traveller communities*. House of Commons Library. <https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/360/full-report.html>

UNICEF. (2023). Benchmarking child-related SDGs. In *UNICEF*.

<https://data.unicef.org/sdgs>

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology*, *18*(1). <https://doi.org/10.1186/s12874-018-0594-7>

Villani, J., Daly, P., Fay, R., Kavanagh, L., McDonagh, S., & Amin, N. (2021). A community-health partnership response to mitigate the impact of the COVID-19 pandemic on Travellers and Roma in Ireland. *Global Health Promotion*, *28*(2), 46–55. <https://doi.org/10.1177/1757975921994075>

Vohra-Gupta, S., Petruzzi, L., Jones, C., & Cubbin, C. (2022). An intersectional approach to understanding barriers to healthcare for women. *Journal of Community Health*, *48*(1), 89–98. <https://doi.org/10.1007/s10900-022-01147-8>

Wang, E., Glazer, K. B., Sofaer, S., Balbierz, A., & Howell, E. A. (2021). Racial and ethnic disparities in severe maternal morbidity: A Qualitative Study of Women's Experiences of peripartum care. *Women S Health Issues*, *31*(1), 75–81. <https://doi.org/10.1016/j.whi.2020.09.002>

Wang, P., Wei, C., McFarland, W., & Raymond, H. F. (2024). The development and the assessment of sampling methods for Hard-to-Reach populations in HIV surveillance. *Journal of Urban Health*, *101*(4), 856–866. <https://doi.org/10.1007/s11524-024-00880-w>

- Ward, Z. J., Atun, R., King, G., Dmello, B. S., & Goldie, S. J. (2023). Simulation-based estimates and projections of global, regional and country-level maternal mortality by cause, 1990–2050. *Nature Medicine*, *29*(5), 1253–1261.
<https://doi.org/10.1038/s41591-023-02310-x>
- Yoon, B., & Uliassi, C. (2022). “Researcher-As-Instrument” in Qualitative Research: The complexities of the educational researcher’s identities. *The Qualitative Report*.
<https://doi.org/10.46743/2160-3715/2022.5074>
- Zarth, M. D., Fernández, P. A., Baggio, M. A., Zilly, A., Gamarra, C. J., & Da Silva, R. M. M. (2024). Cross-cultural nursing care for immigrant women during pregnancy and childbirth: experiences and vulnerabilities. *Revista Gaúcha De Enfermagem*, *45*. <https://doi.org/10.1590/1983-1447.2024.20230161.en>
- Zhang, C., & Lu, J. (2023). Changes and determinants of maternal health services utilization in ethnic minority rural areas in Central China, 1991–2015: An Ecological Systems Theory perspective. *Healthcare*, *11*(10), 1374.
<https://doi.org/10.3390/healthcare11101374>

TAKE PART IN AN ACADEMIC STUDY ABOUT GRT MATERNAL CARE

Participation Requirements:

- 18 years old or older
- Identify as GRT (Gypsy, Roma, or Traveller)
- Have given birth at least once in the last 3 years
- Received maternal health care in the UK

What's Involved?

- A confidential 1 hour interview face-to-face in Midlands or London or online anywhere in the UK via Zoom
- Participants will receive a £15 Amazon voucher

For any questions, contact Sarah at:
Sarah.engelebertcrowson@waldenu.edu

OR

Scan the QR code for more details



Appendix B: Physical Recruitment Poster



Participants needed for an academic research study about GRT maternal care

Participation Requirements:

- 18 years old or older
- Identify as GRT (Gypsy, Roma, or Traveller)
- Have given birth at least once in the last 3 years
- Received maternal health care in the UK

What's Involved?

- A confidential 1 hour interview face-to-face in Midlands or London or online anywhere in the UK via Zoom
- Participants will receive a £15 Amazon voucher

For any questions, contact Sarah at:
Sarah.engebertcrowson@waldenu.edu

OR

Scan the QR code for more details



Appendix C: Interview Protocol

Date of interview:

Start time:

End time:

Name of interviewee:

Participant number:

Recording device used:

Thank you for agreeing to talk to me today. My name is Sarah Englebert Crowson and I am a PhD student at Walden University in the United States. I would like to talk to you today about your experiences with the healthcare system in the United Kingdom during any pregnancies that you have had in the last 3 years. In particular, I am interested in how your culture has impacted your experiences.

This interview has 22 questions and will take approximately an hour to complete. If at any point in the interview, you do not understand a question and would like me to restate it, please let me know. As well, if at any point you wish to pause or stop the interview, please let me know and I will do so immediately. I will be using a recording device to accurately capture all of your answers. This allows me to focus on our interview and take important notes. You will not be identified by name in any recordings or in the findings of this study.

The findings of this study can be provided to you upon the completion of this dissertation. Would you like me to email you a link to the completed dissertation when

that is ready? Do you have any other questions for me before we begin? May I have your verbal permission to begin recording and start the interview?

Interview Questions

I would like to begin by asking you a few basic information questions. These questions will help me be sure you meet the study requirements and answer some of the research questions.

- 1) Do you consider your self GRT? Yes No
- 2) 2. Have you given birth at least once in the last 3 years? Yes No
- 3) What is the total number of pregnancies you have had?
- 4) What are the total number of live births you have had?
- 5) How old are you?
- 6) What is the highest level of education/grade you completed?
- 7) Are you: Married Single Divorced Living with your partner?
 - a) If married, what age were you when you got married?

Thank you for sharing this information. Next, we are going to discuss the research questions. If you would like to pause or stop at any time, please let me know and we can stop right away.

- 8) Tell me about yourself and your experiences growing up in your GRT community.

- a) Did you move around a lot growing up? If so, what was that like?
 - b) Describe any GRT customs that meant a lot to you growing up.
- 9) What were you taught or what did you observe about pregnancy and childbirth growing up in your community?
- a) Were there customs, stories, or advice passed down by family or elders?
- 10) Can you walk me through your most recent experience of being pregnant and giving birth?
- a) What stands out most from that time?
- 11) What does having a “healthy pregnancy” mean to you personally?
- a) How do you think this compares to what others in your community or family believe?
- 12) What cultural or religious beliefs were important for you to keep during pregnancy or birth?
- a) Can you describe how those beliefs were respected or not respected in healthcare settings?
 - b) Tell me about any times you felt you had to change or compromise those beliefs?
- 13) Please describe any family or cultural ways of caring for pregnancy or birth health-wise that are important to you or your community.

- a) How do these practices fit with or differ from what you received from healthcare professionals?
- 14) How did you use technology, like apps or the internet, during your pregnancy?
- a) What kinds of things did you search for or use it for?
 - b) Did you face any problems using these technologies?
- 15) Who supported you most during your pregnancy and childbirth, and what did that support look like?
- a) Were there specific people—family, elders, or professionals—you relied on?
- 16) In what ways was it important to have family or community members involved in your pregnancy and birth?
- 17) Tell me about a time when you were aware of any rules, laws, or NHS policies helped make your healthcare experience easier?
- a) Can you describe any rules or policies that made it harder to get the care you needed?
- 18) Can you describe a time when you felt judged, misunderstood, or worried about being reported during a healthcare visit?
- 19) How did things like cost, transportation, or other responsibilities affect your ability to get care before or after giving birth?

- 20) What changes or support would make pregnancy and childbirth easier for you or other GRT women?
- 21) What do you wish nurses, midwives, or doctors understood better about caring for GRT women during pregnancy and birth?
- 22) Is there anything else about your pregnancy and birth experiences that you would like to share?

Conclusion

I would like to thank you very much for taking the time to participate in this study. Your help has been invaluable, and I sincerely appreciate your participation. If you think of any questions related to the study, please don't hesitate to reach out to me via email.

Appendix D: Application of interview questions with the CCT core concepts

Table 4*Application of Interview Questions to Sunrise Enabler Model Arms*

Question number(s)	Sunrise Enabler arm
14, 14a, 14b	Technical factors
12, 12a, 12b	Religious & philosophical factors
8, 8a, 9, 15, 15a, 16	Kinship & social factors
8b, 9a, 11a, 13a	Cultural values, beliefs, & lifeways
17, 17a, 18	Political & legal factors
19	Economic factors
6, 14b	Educational factors
13, 13a	Generic (folk) care

Table 5*Application of interview questions to CCT core concepts*

Question numbers	CCT concept
8b, 9a, 12, 12a, 13, 13a, 20, 21	Cultural preservation and maintenance
12b, 13a, 17a, 20, 21	Cultural accommodation and negotiation

Appendix E: Codes, Categories, and Themes along with RQ association

Table 6*Codes, Categories, and Themes*

Code	Category	Theme
Family Advocacy	Advocacy & Mediation	Family and Women as the Primary Care System (<i>RQ 1</i>)
Liaison as Link	Family and Care & Stability	
Family as Stability	Women's Authority in Care	
Family as Emotional Support	Gendered Role Boundaries	
Collective Community Care for Mom	Reproductive Experience	
Baby as Part of Larger Family		
Only Family Knows You		
Women as Knowledge Holders		
Matrilineal Caregiving		
Pregnancy as Women's Domain		
Husband Uninvolved with Medical Care		
Gendered Bodily Boundary		

Moral Modesty

Knowledge with Repeated
Pregnancies

Bodily Protection	Bodily Care Practices	Cultural Definition of Maternal Health and Responsibility (<i>RQ 2</i>)
Embodied Monitoring	Food, Strength, & Recovery	
Nutrition as Health	Maternal Responsibility Model	
Traditional Nutrition	Folk Belief – Objects & Luck	
Outcome Based on Maternal Influence	Folk Belief – Spirit & External Influence	
Emotional Influence on Baby	Cultural Continuity & Pride	
Calm as Health Indicator		
Stoicism in Pregnancy		
Folk Charms		
Superstition		
Belief in Spirit Influence		
Cultural Pride		
Cultural Gathering Importance		
Belief that Traditional Ways are Best		

Respectful Care	Healthcare Interaction - Positive	Negotiated Encounters with the Healthcare System (<i>RQ 1</i>)
Affirming Communication	Healthcare Interaction - Negative	
Institutional Respect	Education & Literacy Gaps	
Acceptance of Modern Medicine	System Barriers & Design Mismatch	
Dismissal of Concern	Technology Engagement	
Frustration with Care Procedures		
Not Asking Preferences		
Lack of Education		
Institutional Barriers		
System Inflexibility		
Medical Jargon Barrier		
Health Information Overload		
Selective Technology Use		
Technology Mistrust		
Surveillance Awareness	Surveillance & Stigma	Surveillance, Stigma, and Conditional Dignity (<i>RQ1 & RQ 2</i>)
Perceived Suspicion	Dignity & Respect	

Experienced Stigma

Ethnic Profiling Concern

Social Exclusion

Desire for Dignity

Mobile Childhood	Mobility	Mobility & Settlement (<i>RQ 1</i>)
------------------	----------	---------------------------------------

Normalization of Mobility Settlement

Lack of Permanence

Settlement

Appendix F: Copyright Permission for Figure 1

SAGE PUBLICATIONS LICENSE
TERMS AND CONDITIONS

This Agreement between Sarah Englebert Crowson ("You") and Sage Publications ("Sage Publications") consists of your license details and the terms and conditions provided by Sage Publications and Copyright Clearance Center.

License Number	6010171009518
License date	Apr 15, 2025
Licensed Content Publisher	Sage Publications
Licensed Content Publication	Journal of Transcultural Nursing: A Forum for Cultural Competence in Health Care
Licensed Content Title	Leininger's Theory of Culture Care Diversity and Universality: An Overview With a Historical Retrospective and a View Toward the Future
Licensed Content Author	Marilyn R. McFarland, Hiba B. Wehbe-Alamah
Licensed Content Date	Nov 1, 2019
Licensed Content Volume	30
Licensed Content Issue	6
Licensed Content Pages	18
Type of Use	Dissertation/Thesis
Requestor type	I am NOT the author of the requested article
Format	Electronic
Portion	Figure/table
Number of figures/tables	1
Will you be translating?	No, only English
Circulation	1
Title of new work	Experiences of maternal care in the Gypsy, Roma, and Traveller population in the UK: A Cultural Care Model
Institution name	Walden University
Expected presentation date	Jan 2026
Portions	Figure 3, Sunrise Enabler
The Requesting Person / Organization to Appear on the License	Sarah Englebert Crowson
Requestor Location	Ms. Sarah Englebert Crowson 66 Main Street

Customer Tax ID	Kilby, LE18 3TD United Kingdom GB593589855
Payment Type	Invoice Ms. Sarah Englebert Crowson 66 Main Street
Billing Address	
Total	Kilby, United Kingdom LE18 3TD 0.00 GBP
Terms and Conditions	

Sage Terms and Conditions for Permissions Administered Through RightsLink

You, the Requestor, are requesting to use the material specified in the permission request (the "Work"). Your agreement to the terms and conditions herein and completion of a permission request constitutes a Permission Request. You are in no way required to use the Work; however, should you decide not to use the Work after you complete this request, you agree to cancel your order through this website. Under the above conditions, and the following terms and conditions, permission to use Work ("Permission") is granted solely to you:

1. Sage reserves the right to revoke any Permission, at Sage's sole discretion, within two (2) business days of the request.
2. The number of copies ("Copies") for print use is defined as the total number of copies made for distribution or for repurposing, and the number of copies ("Copies") for electronic use is defined as the total number of viewers of the Work, recipients of copies of the Work, and individuals or entities who may have access to the Work. The Copies must not exceed the Copies as stated in the Permission Request.
3. Requests to post a full article on a website, internet, intranet, or any publicly accessible site must be submitted to the Publisher through the Sage Permissions Portal (<https://sage-cloud.atlassian.net/servicedesk/customer/portal/10>).
4. Permission is granted only for the type of use specified in the Permission Request. If any information pertaining to your Permission Request changes, you must cancel this request and resubmit a new request with the correct and current permission request information. Sage may exercise its right to revoke Permission, if Sage finds, in Sage's sole opinion, that the context in which you have used or repurposed the Work is considered libelous, in violation of any right of privacy, or otherwise unlawful; infringement or in violation of any copyright or other proprietary right of others; or can be construed to possibly cause harm or injury. You agree that use of

Work will be professional, in the context of fact-based and generally acceptable professional practices.

5. Permission does not include the use within Custom Publishing Programs, and all use within such programs is explicitly prohibited.
6. Permission does not include use of the material within Massive Open Online Courses (MOOC's). For permission to include material in a MOOC, please contact Sage directly through the Sage Permissions Portal (<https://sage-cloud.atlassian.net/service desk/customer/portal/10>).
7. If your Permission Request includes the right to translate the Work, you agree that the translation of the material shall be made faithfully and accurately, and that abbreviations and/or alterations in the text and/or title of the Work shall be made only with Sage's prior the written consent. Requestor shall not own or acquire any copyright or other proprietary rights in the Work or any other material furnished by Sage, including without limitation translations or transcriptions thereof, all of which rights shall be owned by and/or are hereby assigned to Sage. Requestor shall indemnify Sage against any and all claims, including without limitation attorneys' fees and legal costs, that concern or relate to (a) inaccurate translation or transcription of the Work, (b) infringement claims arising out of the inclusion of material not furnished by Sage or (c) infringement or other claims asserted by anyone retained by Requestor to translate the Work. Requestor agrees that the name of the Author (s), Copyright Holder, and Publisher shall appear in due prominence on the title page of every copy of the translation and in all advertisements for the translation, and that the translation shall include: (1) the Work's original copyright notice and original American title, both in English, and (2) notice in granted translated language in identifying the Sage Publications as the original publisher and stating the translation is published by arrangement with Sage. The rights licensed to Requestor are not transferrable. The translated article reprint must include the following disclaimer in English and in the language of the reprint: "While every effort has been made to ensure that the contents of this publication are factually correct, neither the authors nor the publisher accepts, and they hereby expressly exclude to the fullest extent permissible under applicable law, any and all liability arising from the contents published in this Article, including, without limitation, from any errors, omissions, inaccuracies in original or following translation, or for any consequences arising therefrom. Nothing in this notice shall exclude liability which may not be excluded by law. Approved product information should be reviewed before prescribing any subject medications."
8. Permission is granted for prospective use only, and does not apply to any use that has occurred prior to the date of the Permission Request.
9. Permission does not apply to any material (reprints, illustrations, figures, tables, etc.) not controlled by Sage. Requests for permission to re-use third-party material should be submitted to the original copyright holder, as indicated in the credit line for the materials.

10. Full acknowledgment of your source must appear in every copy of your work as follows:

Author(s), Book/Journal Title (Journal Volume Number and Issue Number)
pp. xx-xx. Copyright © YEAR by (Copyright Holder). Reprinted by
Permission of Sage Publications

11. Unless specified in the request or by prior arrangement with Sage, payment is due from you within sixty (60) days after the completion of Permission.
12. It is assumed that the Requester is using the selection in question, and is subject to billing and collections procedures, unless otherwise noted.
13. Permission Requests for reuse of text excerpts shall not exceed 50% of a journal article's content.
14. No more than 20% of any one Sage book or journal issue may be reused at one time.

Other Terms and Conditions:

v4.06

Questions? customercare@copyright.com.