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Gayathri Delanerolle and Peter Phiri *

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Concept Paper

The Delanerolle and Phiri Theory: The basis to the *Novel* Culturally Informed ELEMI Qualitative Framework for Women's Health Research

Gayathri Delanerolle [1] and Peter Phiri [1,2,*]

[1] Hampshire and Isle of Wight Healthcare NHS Foundation Trust, Southampton, UK
[2] University of Southampton, Southampton, UK
* Correspondence: peter.phiri@southernhealth.nhs.uk

Abstract

Complex women's health conditions extend beyond biological transitions, encompassing physiological, psychological, and sociocultural dimensions that make their understanding and management inherently multifaceted. Midlife women's health, particularly during menopause, is shaped not only by hormonal changes but also by lived experiences, societal expectations, and cultural narratives that influence symptom perception and expression. Yet, mental and physical health sequelae are often examined in isolation: vasomotor, genitourinary, and long-term risks such as osteoporosis dominate clinical focus, while psychological effects, anxiety, depression, cognitive changes, and identity shifts, are underexplored. This fragmented approach undermines the biopsychosocial nature of women's health, where mind and body interact bidirectionally. Qualitative evidence from the MARIE project across twelve countries highlights the role of cultural norms and beliefs in shaping women's menopausal experiences, with some cultures framing menopause positively and others associating it with stigma. Women frequently adopt culturally rooted remedies or self-care practices, yet current qualitative methodologies insufficiently capture such cross-cultural complexities. Established approaches like grounded theory, phenomenology, narrative inquiry, and ethnography offer valuable insights but often minimize or overlook cultural, racial, and contextual variations. Intersectional and feminist theories address gender and power but lack a systematic framework for comparative, cross-cultural health research. To address this gap, the Delanerolle and Phiri Theory is proposed as a novel qualitative framework. Grounded from evidence from MARIE, it integrates physical, psychological, and cultural dimensions, offering a methodology that explicitly embeds culture and identity at every research stage. This theory advances a more holistic understanding of women's health in multicultural contexts.

Keywords: Delanerolle and Phiri; theory; qualitative framework; women's health research

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Background

Complex women's health conditions present multifaceted challenges that extend beyond simple biological transitions. These stages encompass physiological, psychological, and sociocultural dimensions, making their understanding and management inherently complex. Women's health during midlife is influenced not only by hormonal changes but also by individual life experiences, societal expectations, and cultural narratives that shape how symptoms are perceived and expressed (Delanerolle et al., 2025; Hall, Callister, Berry, & Matsumura, 2007).

The mental and physical health sequelae is deeply interconnected, yet they are frequently explored and treated in isolation. Physical manifestations such as vasomotor symptoms, genitourinary changes, and long-term risks like osteoporosis among menopausal women dominate clinical discourse. Conversely, psychological effects including anxiety, depression, cognitive disturbances, and changes in self-identity are studied separately, if at all. This fragmented approach

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fails to capture the biopsychosocial nature of women's health, where mental well-being can exacerbate or alleviate physical symptoms and vice versa (Hall et al., 2007).

This separation of focus has led to significant challenges in research, clinical practice, and policy. Research often produces incomplete evidence, overlooking the bidirectional relationships between mind and body. Clinically, fragmented care pathways result in treatments that address physical symptoms without considering psychological needs, or vice versa, leaving many women without comprehensive support. At a systemic level, health policies and service delivery models rarely integrate multidisciplinary approaches, perpetuating inequities in care and understanding of these complex conditions.

Rationale

Qualitative evidence from the MARIE project conducted across the UK, Malaysia, Tanzania, Sri Lanka, India, Pakistan, Nepal, Singapore, Nigeria, Ghana, Rwanda, Oman, and Brazil highlights how cultural norms, beliefs, and traditional practices shape women's perceptions and coping strategies during menopause. In some cultures menopause is viewed positively as a transition into wisdom and elderhood while in others it is shrouded in stigma or taboo. Many women turn to culturally rooted remedies or "natural" self-care methods such as diet changes, herbs, religious rituals to manage symptoms (Ilankoon, Samarasinghe, & Elgán, 2021). Yet, current qualitative research theories rarely center these cultural variations and intersections of race, ethnicity, and belief systems. As a result, important nuances and "intra-dependencies" the interplay between culture, identity, and health risk being overlooked.

Existing qualitative methodologies such as grounded theory, phenomenology, narrative inquiry and ethnography have provided valuable insights but are not specifically tailored to women's health or disease sequelae in multicultural contexts (Charmaz, 2014; Clandinin & Caine, 2013; Eberle, 2014; Naidoo, 2012). Grounded theory aims to let themes emerge inductively, but its classic form kept cultural factors mostly implicit, critics note that differences of race, ethnicity, and culture often become erased in the generalising of grounded theory analyses. Phenomenological approaches seek the essence of experiences, sometimes bracketing out context, which may gloss over how *sociocultural context* influences what menopause means to different women. Likewise, narrative and ethnographic methods typically focus on single-culture stories or require deep immersion in one community, making cross-cultural comparisons challenging. Feminist and intersectional theories do call attention to gender, race, and power, but they function more as analytical lenses than step-by-step research methods, and they have not produced a unified methodology for comparing health experiences across diverse global cultures. In short, no existing framework fully integrates physical health, mental health, and cultural context in qualitative research on women's health. There is a clear need for a new theory and methodology that fill this gap.

The *Delanerolle and Phiri Theory* is proposed as an entirely novel qualitative framework to meet this need. It is grounded in insights from the MARIE multi-country menopause study and similar evidence, which underscore that women's health experiences are culturally mediated and multifaceted. This theory asserts that to truly understand complex conditions and their sequelae in women's lives, qualitative research must explicitly account for culture and identity at every stage from how we design studies to how we interpret narratives. Below, we introduce the key tenets of the Delanerolle and Phiri theory and its co-developed methodology, followed by a comparison to existing approaches and practical guidance for applying this framework in research and practice.

Methodology

The Delanerolle and Phiri Theory – Core Concepts

Delanerolle and Phiri's theory is a culturally informed, holistic lens for qualitative research on women's health. It posits that a woman's experience of a health condition such as menopause is co-

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constructed based on 3 core principles that shapes perception, meaning and behaviour are listed below (Table 1);

Table 1. The principles linked to the Delanerolle and Phiri theory.

Principles	Scope
Biological changes and physical symptoms	Encompassing biological and physiological factors that leads to symptoms that are expressed as experiences
Psychological and emotional responses	Psychological, mental health wellbeing components expressed as experiences
Sociocultural context	Encompassing culture, ethnicity, race, religion, community norms, and traditional knowledge

Attitudes and cultural perceptions provide the very *context* in which women experience health changes. Some defining features of the theory include cultural relativity of experience, intersectional and intra-dependent factors, incorporation of traditional and complimentary medicine, dynamic storytelling, holistic approaches to health and the consideration of disease sequalae.

Cultural Relativity of Experience

Women's narratives of illness or life transitions are understood on their own cultural terms. The theory acknowledges that what may be labelled a "symptom" or a problem in one culture could be seen as a normal aging process or even a positive milestone in another. For instance, whereas Western biomedical perspectives often highlight menopausal symptoms as issues to be treated, many women in Asian settings report fewer symptoms or consider menopause a *natural stage* of life to be managed privately. The Delanerolle and Phiri theory emphasises documenting these culturally specific meanings (e.g. menopause as "natural aging" vs. "medical condition") without imposing one dominant viewpoint.

Intersectional and Intra-dependent Factors

Building on intersectionality, the theory accounts for how *multiple aspects of identity and context intersect*. Race, ethnicity, socioeconomic status, family role, and religion interweave to influence health experiences. Importantly, Delanerolle and Phiri go beyond broad intersectionality by examining *intra-dependencies* – the dynamic interactions between factors. For example, a woman's cultural background might influence her openness to discussing menopause (due to stigma or norms), which in turn affects her mental health (if she "suffers in silence" due to taboo). Simultaneously, her physical symptoms might drive her to seek remedies aligned with her belief system (like herbal medicine or prayer), which are supported by her community. The theory provides a framework for analysing these feedback loops: how culture shapes coping and health outcomes, and how the experience of health issues can, conversely, reshape one's social roles or beliefs.

Incorporation of Traditional and Complementary Medicine

A unique stance of this theory is recognizing alternative medicine and indigenous health practices as integral to many women's health strategies worldwide. Rather than treating "complementary and alternative medicine" (CAM) as a side note, Delanerolle and Phiri theory weaves it into the understanding of health behaviour. Women often turn to remedies passed down through generations whether Ayurvedic treatments in South Asia, plant-based medicines in Africa, or spiritual healing rituals and these choices are tied to cultural identity and trust. Our theory asserts

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that qualitative research must explore these practices and their meanings. For example, in Africa some women "remember our African treatments and trust them" as accessible options when Western treatments are unaffordable or alien. By documenting such practices, researchers can uncover culturally specific approaches to managing symptoms such as eating certain foods to reduce hot flashes, wearing traditional attire as a form of comfort or identity during midlife, which are often overlooked in mainstream health research.

Dynamic Narratives and Storytelling

The Delanerolle and Phiri theory views personal narratives not just as data, but as *products of culture* and *vehicles of meaning*. Women's stories about their health are shaped by available cultural narratives, for instance, whether menopause is spoken of openly or kept private. This theory encourages eliciting narratives rich, storytelling accounts of experiences to capture the full context. By hearing a woman describe, say, how her community views a menopausal woman respected elder versus someone "no longer useful," as some myths might say, we gain insight into how she internalizes or resists those views. The theory holds that qualitative data collection should facilitate narrative expression through open-ended prompts, life-story approaches, allowing women to frame their experiences in their own cultural terms and metaphors. These narratives are then analysed for both their content such as what happened, and cultural subtext such as why it's described that way, what norms or values underlie the story.

Holistic View of Health (Physical-Mental-Cultural)

Fundamentally, Delanerolle and Phiri theory is *holistic*. It refuses to silo physical health from mental health, or individual experience from community context. For example, it recognizes that menopausal hormone changes can trigger mood swings or depression, but whether these are openly acknowledged or attributed to other causes can depend on culture

Disease sequalae

Physical "disease sequelae" such as osteoporosis risk post-menopause might only be addressed if the cultural context allows women to seek preventative care highlighting a policy gap if cultural stigma prevents discussion. Thus, our theory prompts researchers and practitioners to consider the entire ecosystem of a woman's life; biology, psychology, family expectations, cultural health literacy, and available support systems. It aligns with calls for *culturally responsive care* in women's health, advocating that understanding a woman's culture and beliefs is as important as understanding her lab results.

The Delanerolle and Phiri Qualitative Approach

Theory and methodology in this framework are co-dependent, evolving together. The Delanerolle and Phiri methodology is designed to capture the rich, culturally situated data that the theory envisions. It can be characterised as a "*Narrative Funnel*" approach with a "*Pragmatic and Culturally Adaptive*" design. Key features of this methodology has been represented in Table 2:

Table 2. Key features of the Delanerolle and Phiri methodology.

Features	Scope	Example
Funnel-Based Interview Design	Researchers using this method employ a *broad-to-narrow interviewing strategy*. At the start of data collection, very open-ended,	Participants might be prompted with general questions like, "Can you tell me about your experience of midlife changes?" or "How do

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	exploratory interviews (or focus group discussions) are conducted to cast a wide net. Such a funnel approach beginning broadly and then progressively honing in on specific topics is a well-regarded tactic in qualitative guide development. It mitigates bias and helps ensure important issues emerge naturally before the investigator introduces any narrower, pre-defined questions.	women in your community view menopause?" This allows participants to raise the themes that matter to them, in their own cultural framing, without being immediately steered by the researcher.
Narrative and storytelling techniques	In alignment with the theory's emphasis on narrative, the methodology encourages use of narrative interviewing techniques.	Participants might be asked to share a story (e.g. "Tell me about a day when you really felt the impact of menopause" or "Share how your mother or older women in your family talked about these changes"). Interviewers are trained to be active listeners who prompt for stories, anecdotes, and examples, rather than just short answers. This narrative focus tends to yield richer detail and reveals the *cultural context* (since stories often embed norms, values, and communal attitudes).
Pragmatic and flexible data Collection	Consistent with a pragmatic qualitative research paradigm, this methodology is highly flexible and adapts to the real-world context of the study. Researchers are encouraged to employ multiple data sources and methods as needed interviews, focus groups, participant observations, even surveys or	Guiding principle is practicality is to use whatever methods will best uncover the phenomenon in that cultural setting. For example, in a society where women are uncomfortable speaking to outsiders due to cultural modesty, the methodology might involve hiring and training *local female interviewers* who speak the

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	visual methods to get a comprehensive picture.	language and are trusted improving participants' comfort cultural *and* gender sensitivity. In another context, women might prefer sharing in a group (drawing strength from collective discussion); thus, focus groups or "sharing circles" could be utilised initially, followed by individual interviews for personal topics. Flexibility and adaptability are crucial. If early data collection reveals that certain questions are misunderstood or sensitive, researchers can revise their approach with pragmatic iteration. For instance, in some cultures direct questions about sexual health in menopause might shut down conversation; a pragmatic adjustment could be to frame it via hypotheticals or allow participants to bring it up themselves later.
Cultural competence and reflexivity	Those employing the Delanerolle and Phiri approach must engage in continuous reflexivity about their own cultural biases and ensure cultural competence in the research process. This includes practical steps such as translating interview guides with careful attention to local meanings, doing pilot interviews to fine-tune culturally appropriate wording, and involving cultural insiders community members or local researchers in study design	For example, the MARIE project teams in each country could co-design interview questions to make sure they resonate locally. The methodology values collaboration with local stakeholders, whether traditional healers, community leaders, or healthcare providers to shape research questions that are culturally relevant. It also encourages researchers to keep field notes on cultural observations and to discuss within

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		the team how their own assumptions might affect interpretation. By integrating these practices, the methodology guards against misinterpretation and ensures that participants feel respected and understood.
Thematic and comparative analysis	After data collection, the Delanerolle and Phiri methodology uses a two-layer analysis strategy. First, within-case (or within-culture) analysis is done to identify themes, patterns, and narratives specific to each cultural group or country in the study. Researchers might use thematic analysis or content analysis to code transcripts, but with an eye for *cultural keywords* and concepts.	For instance, themes like "menopause as natural aging" or "fear of being seen as old" might emerge in one context, while "seeking herbal solutions" or "menopause and religion" emerge in another. Each context is analysed on its own terms to do justice to its unique data. Then, in line with the theory's goal of understanding *intra-dependencies and variations*, a cross-cultural comparative analysis is conducted. This doesn't mean forcing the same themes across all groups, but rather comparing and contrasting findings to draw out insightful differences and commonalities. For example, researchers might note that both Ghanaian and Pakistani women talk about hot flashes, but the Ghanaian participants frame it with indigenous terminology and remedies, whereas Pakistani participants discuss it in relation to modesty or joint family systems. These comparative insights can lead to a richer theory that explains not just one group but the

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		interplay of culture and experience across many groups.

After this broad exploration, the methodology calls for iterative refinement: researchers analyse the initial narratives for emergent themes and culturally unique concepts. Based on those findings, they design follow-up interview questions that funnel down to specifics, for example, if many women mention using certain herbs or religious rituals for symptom relief, later interviews will include focused questions about those practices (e.g. "How did you learn about this remedy?" "How do others view your use of it?"). In essence, Stage 1 is discovery-driven and wide-ranging, and Stage 2 (and possibly Stage 3, etc.) becomes progressively structured to delve into the discovered themes in depth. This funnel method ensures nothing culturally significant is prematurely filtered out; we "go broad and gather data before refining" rather than starting with a narrow agenda.

For instance, a woman's story about hiding her hot flashes during religious fasting days can illuminate how religious practice intersects with symptom management. Such qualitative data, laden with context, are exactly what the Delanerolle and Phiri theory seeks. The methodology might also incorporate life history interviews or timeline exercises (having women map out key life events around midlife) to situate health experiences within a personal and cultural chronology. By using narrative methods, we capture both *the events* (what symptoms or treatments were tried) and the meaning (why they matter to her, given her background).

The methodology also supports using cultural probes around asking participants to bring an object that represents their experience such as an herbal medicine packet or a prayer book to discuss, if that fits the cultural context. Overall, by being *pragmatic* and context-aware, the method ensures data quality and ethical respect. The emphasis on context is explicit: researchers should have *situational awareness* of local norms, power dynamics, and sensitivities, and adjust methods accordingly.

In one illustration from a similar project in Africa, researchers had to balance biomedical information with respect for traditional beliefs when creating menopause educational resources. Our methodology calls for balancing different knowledge systems: it's acceptable, even encouraged, to gather data on folk explanations of illness (e.g. attributing symptoms to spiritual causes) alongside biomedical ones. Rather than immediately judging one as "incorrect," researchers first seek to understand its cultural logic. This culturally competent stance often *builds trust* with participants, leading to more open sharing. It also means that when analysing data, researchers remain mindful of not imposing their cultural lens – e.g., understanding that a woman saying "I consider menopause a curse" must be interpreted in her cultural context of perhaps strong spiritual beliefs, rather than dismissed as irrelevant.

The analysis process is often *iterative and reflexive*: researchers cycle between data and emerging interpretations, possibly returning to participants or advisors for clarification (a form of member checking). As with any qualitative study, ensuring credibility and trustworthiness is vital – the methodology recommends techniques like member validation of themes, peer debriefings (especially with multicultural team members), and maintaining an audit trail of decisions. Ultimately, the analysis aims to produce a theoretical model or narrative that encapsulates how physical, mental, and cultural factors converge in these women's health experiences. This might be presented as a conceptual diagram (Figure S1) or simply as a richly described set of themes interlinked by the Delanerolle and Phiri theoretical concepts.

In practice, applying this methodology might look like a multi-phase qualitative study: initial exploratory interviews in all sites; analysis to build a preliminary theoretical model; targeted follow-ups or focus groups to test and refine the model (funnel narrowing); and finally, an integrated interpretation that articulates the new theory. The output could be, for instance, the "Delanerolle and Phiri Model of Menopausal Experience," detailing how cultural context filters the physical and emotional reality of menopause. Through this rigorous yet flexible approach, the methodology

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ensures that qualitative data truly "consider race, ethnicity and cultural variation" as the user asked not superficially, but in deep, systematic ways.

Comparison with Existing Theories and Methodologies

The Delanerolle and Phiri theory and methodology stake out a unique stance in the landscape of qualitative research. We compared and contrasted our framework with several well-known theories/methods to highlight its novel contributions, as indicated in Table 3:

Table 3. Comparison between qualitative theories and the Delanerolle and Phiri framework underpinned by the Delanerolle and Phiri theories.

Theory	Context	Positionality	Use	Comparison with the Delanerolle and Phiri Framework
Grounded Theory	Inductive theory-building through iterative coding; focused on social processes; traditionally culture-neutral unless it emerges in data.	Researcher positions themselves as neutral, aiming for minimal preconceptions. Reflexivity not emphasised in classic approaches.	Useful for generating theory in any social setting, but generic in scope. Not tailored to women's health or the biological, psychological, and social complexity of reproductive transitions. This limits its ability to address inequalities in health contexts.	The Delanerolle and Phiri framework integrates biological, psychological, and social factors with culture as a central driver. It positions researcher reflexivity as key and ensures women's health experiences are not abstracted but examined holistically across contexts.
Phenomenology (e.g. IPA)	Focuses on lived experience and seeks to distil the essence of a phenomenon, often abstracted from cultural and social specificities.	Researcher brackets assumptions and positions themselves as an interpreter of subjective experience.	Effective for deep exploration of individual experiences but overly generic. Its search for "essence" sidelines cultural and social drivers, and it is not designed to examine the gendered biological and psychological aspects of women's health.	The Delanerolle and Phiri framework rejects abstraction from context, insisting that lived experience of women's health (e.g. menopause, endometriosis) cannot be separated from cultural, biological, and psychological realities.

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Narrative Inquiry	Collects and analyses personal stories, emphasising temporality, identity, and meaning.	Researcher co-constructs narratives, reflexively acknowledging their interpretive role.	Useful for understanding how individuals make sense of their experiences, but usually focused on small case sets and not designed for systematic comparison across women's health contexts. Its generic design means it overlooks biological and psychological components of health.	The Delanerolle and Phiri framework builds on narrative inquiry but extends across multiple cultural contexts. It explicitly examines how women's health stories are framed by biological changes, psychological states, and cultural expectations, enabling comparative insights.
Ethnography	Immersive, long-term study of a single culture or community, producing holistic insider accounts.	Researcher negotiates insider–outsider roles through immersion and reflexivity.	Powerful for in-depth exploration of cultural practices, but generic in scope and focused on one site. Not structured to examine cross-cultural women's health issues or integrate biological and psychological dimensions alongside culture.	The Delanerolle and Phiri framework is explicitly multi-sited and comparative, addressing women's health across contexts. It integrates biological, psychological, and cultural perspectives, and leverages local collaborators to ensure contextual depth without losing comparative breadth.
Feminist & Intersectional Methodologies	Centring women's experiences and exposing structures of power; intersectionality highlights	Researcher is reflexive, political, often aligned with participants' struggles.	Effective for critiquing systemic inequalities in health, but lacks a specific methodological pathway to systematically capture women's	The Delanerolle and Phiri framework resonates with feminist and intersectional commitments but operationalises them through a structured

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	overlapping oppressions.		health narratives across cultures. Often highlights inequities but does not integrate biological and psychological processes with cultural practices.	method. It systematically integrates biological, psychological, and cultural analysis of women's health experiences across multiple global contexts.

Critical Comparative Overview

Furthermore, GT typically involves theoretical sampling *within* a fairly bounded population to refine one emerging theory. In our method, we deliberately sample across diverse groups/cultures to capture a *spectrum* of experiences. The result is not a single unified theory that ignores cultural outliers, but a contextualised theory that can explain differences. In summary, grounded theory gave qualitative research the idea of letting data speak, but the Delanerolle and Phiri theory ensures that what the data "say" about culture is not lost. It responds to critiques of GT by making race/ethnicity and culture explicit considerations throughout the research process, answering a gap where GT and other methods had "few references to race" historically.

Our theory would argue that instead of one essence, there are multiple culturally-influenced essences or narrative realities of the same biological transition. Methodologically, IPA and phenomenology use in-depth interviews and reflective analysis, similar to us, but they typically use smaller homogeneous samples to dig deep into one group's experience. We, on the other hand, encourage comparative work and diverse sampling to explicitly surface heterogeneity. One could say phenomenology seeks convergence such as what is common in experience, whereas *Delanerolle & Phiri* also seeks divergence as what is distinct and why, across cultures. Both approaches value subjective experience, but ours places those experiences in socio-cultural relief, aligning more with critical phenomenology or feminist phenomenology that acknowledge power and context. Our approach also extends beyond description to actionable theory that can guide interventions for specific cultural groups, something traditional phenomenology might not aim to do.

Additionally, our methodology's funnel technique is an added structure on narrative collection, narrative inquiry might just invite free storytelling, whereas we combine free storytelling with strategically *targeted follow-ups* to ensure certain comparators (like we might specifically ask all participants, eventually, about mental health or sex life or traditional remedies, to have those points of comparison). Thus, we transform individual narratives into a collective, culturally stratified narrative that feeds theory. The theory we build is not purely an emergent storyline, but a conceptual model that explains how different narratives are shaped by cultural forces (in narrative research terms, we are interested in the *cultural narrative templates* that underlie personal stories).

Another point: ethnography doesn't always produce *theory*; often it produces a descriptive account or conceptual insights grounded in one culture. Our goal, however, is to generate a mid-range theory that is *transferable* and can inform understanding and practice across settings – something ethnography alone might not generalize. We share ethnography's commitment to cultural sensitivity and insider perspective, but differ by our comparative ambition and our integration of health outcomes (physical/mental) into the cultural analysis.

Another difference is that our theory isn't explicitly framed as a critique or emancipatory agenda (though it can be used in that way); it is descriptive-analytical but can feed into emancipatory outcomes by informing policy (e.g. revealing that certain women lack voice or access in specific cultures, thereby highlighting a need for change). In contrast, feminist methodologies often start with an explicit goal of empowerment or advocacy. Delanerolle & Phiri theory can certainly empower (it

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emphasizes listening to marginalised voices, e.g. indigenous women's knowledge), but it packages itself as a *framework for understanding* first, with action as a next step. We also integrate mental and physical health equally, whereas some feminist health studies might emphasize social aspects and less the biological (or vice versa). Our theory says both matter together, and cultural context binds them.

Delanerolle and Phiri theory stands out by combining elements of various approaches but adding its own novel integration. It has the inductive openness of grounded theory but with a cultural lens from the start; it values the lived experience like phenomenology but insists those experiences are culture-bound; it embraces story and context like narrative and ethnography but with systematic comparison across contexts; and it champions women's voices and diversity akin to feminist/intersectional approaches while delivering a concrete methodology for global health research. Most importantly, it is *tailored to women's health and disease sequelae*, addressing aspects (like menopause, alternative medicine use, cultural stigma) that prior generic theories did not specifically account for. No existing approach offers this combination of narrative depth, cultural breadth, and practical guidance for understanding complex health experiences in a global perspective.

Implications and Guidance for Policy, Research, and Practice

Developing a new theory is only as useful as its application. The Delanerolle and Phiri theory, with its associated methodology, has significant implications for various stakeholders from policymakers to academic researchers to clinicians. We outline practical guidance in Table 4 for each group to leverage this framework in improving women's health understanding and outcomes:

Table 4. Applications of the Delanerolle & Phiri Framework.

Audience	Key Focus Area	Application	Illustrative Example
Policymakers & Public Health Planners	**Culturally Tailored Health Policies**	Develop policies that address cultural barriers and needs in women's midlife health, avoiding one-size-fits-all models.	In Sri Lanka, public health campaigns can distinguish between "normal" menopausal symptoms and those requiring medical care, using culturally respectful terms and analogies.
	Inclusion of Cultural Competency in Programs	Require cultural competency training for staff in health programmes and localise interventions.	Awareness campaigns in Ghana vs. Nepal use different narratives: one addressing silence around menopause, another tackling stigma about women's value post-menopause.
	Resource Allocation for Research & Traditional Medicine	Fund cross-cultural women's health research and safe integration of traditional medicine into healthcare systems.	Governments regulate and endorse safe herbal remedies alongside HRT, while funding multinational studies like MARIE.
Academic Researchers & Scholars	**Adoption & Refinement of Methodology**	Apply the framework to study other women's health conditions and develop specific tools.	Extending the methodology to infertility or postpartum depression, producing culturally sensitive interview guides.

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	Analytic Lens	Use the framework to re-analyse existing multi-ethnic qualitative data, adding cultural depth.	Applying the framework to an existing breast cancer survivorship study to uncover cultural influences on coping.
	Teaching & Mentorship	Incorporate the framework into qualitative research training to highlight gaps in older theories.	Supervisors guide students to let culture shape conversations in fieldwork, improving ethics and validity.
	Interdisciplinary Collaboration	Bridge anthropology, sociology, and health sciences through a shared cultural-health lens.	A medical researcher and anthropologist co-lead a menopause study, combining biomedical and cultural expertise.
Clinicians & Healthcare Providers	**Culturally Sensitive Clinical Practice**	Integrate awareness of cultural beliefs into patient interactions to improve trust and outcomes.	A South Asian woman is asked about Ayurvedic remedies; advice is tailored respectfully around her choices.
	Integrating Traditional & Biomedical Care	Respect and evaluate cultural remedies alongside medical treatments for safe, effective care.	A Nigerian woman's herbal tonic for hot flushes is checked for safety and incorporated into her care plan.
	Advocacy & Education	Use cultural insights to educate patients and communities, reducing stigma and silence.	Clinicians lead workshops normalising menopause, provide materials in local languages, and counter harmful myths.

The Delanerolle and Phiri framework provides distinct value for policymakers, researchers, and clinicians by embedding biological, psychological, and social dimensions within cultural contexts of women's health. For policymakers, it highlights the inadequacy of universal approaches and supports the development of culturally sensitive health policies, culturally competent programmes, and funding structures that recognise traditional medicine and global comparative research. For academic researchers, it offers both a methodology (Figure S2) and analytic lens, encouraging the refinement of tools, cross-cultural reanalysis of existing data, and integration into teaching, mentorship, and interdisciplinary collaborations. For clinicians, it strengthens culturally sensitive practice by promoting dialogue with patients about beliefs, supporting the safe integration of traditional and biomedical care, and enabling advocacy that reduces stigma and misinformation. Collectively, the framework bridges gaps between generic theories and the lived realities of women's health, ensuring that interventions, scholarship, and care are contextually grounded and globally inclusive.

Conclusions

The Delanerolle and Phiri theory provides a theory and methodology based on a pioneering conceptual scaffold having carefully consider clinical complexities, race, ethnicity, and cultural

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variation in qualitative research on women's health experiences. It urges researchers to treat cultural context and diversity not as confounders to be controlled, but as central variables of interest, pushing qualitive research beyond narratives to truly represent the diverse experiences, perceptions and beliefs. By applying this novel theory and framework, qualitative research in women's health can now be used to develop fit-for purpose interventions, clinical practice guidelines and policies. Ultimately, the Delanerolle and Phiri approach champions the idea that women's health experiences are not monolithic and that acknowledging cultural variation is not a mere add-on, but a necessity for accuracy and equity in both research and practice. Through this lens, we can better navigate the rich tapestry of women's health globally, leading to more inclusive knowledge and improved well-being.

Supplementary Materials: The following supporting information can be downloaded at the website of this paper posted on Preprints.org.

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