**‘This Should be the Answer!’:**

**The Evolution of Relational Dynamic Capabilities in the Co-Production of Maternity Care Services to Vulnerable Women**

**ABSTRACT**

Established models of maternity care delivery in high-income countries have increasingly proved inadequate to address the highly idiosyncratic and heterogenous needs of vulnerable pregnant women, such as ethnic minorities, migrants and asylum seekers, who still disproportionately suffer from high maternal morbidity and mortality. Intersectionality theory has been salient to represent vulnerable women’s lived, subjective experience of inequity in healthcare access; however, it has proved less effective in informing organisational and systemic change able to redress the intersectional disadvantage affecting vulnerable populations.

To address these theoretical and empirical gaps, this article develops an in-depth single case study around the HAAMLA team, a specialised community midwifery group active at the Leeds Teaching Hospital NHS Trust in England (UK), which specifically evolved over time to cater to the needs of vulnerable pregnant women. We conducted semi-structured interviews with the midwives and team leadership and triangulated our data with archival material and participant feedback. Building abductively on a novel intersectional, socio-ecological theoretical framework, our findings highlight how HAAMLA midwives developed a radically different model of maternity care delivery that conceptualises vulnerability as an intersectional, socially constructed category and that co-produces holistic, bespoke care services together with the women and with the external network of partner agencies. In doing so, the team developed and leveraged two key relational dynamic capabilities: adaptive network activation and trust-based relationship building. The article discusses contributions to theory, policy and practice, while providing fresh insight into a strongly innovative and potentially replicable model of maternity care delivery to vulnerable groups.

**Keywords**: Maternity care; vulnerable women; intersectionality; socio-ecological theory; network governance; English National Health Service (NHS).

**INTRODUCTION**

Pregnant women and new mothers in the perinatal period (until 12 months after birth) with social risk factors or living in vulnerable circumstances have become ‘vulnerable’ in the common understanding of this term (Rayment-Jones et al., 2019; van Blarikom et al., 2022). However, the social construction of pregnancy and early motherhood differs depending on who the mother is, her social position, and the physical, geographical and political context within which she finds herself. Pregnant migrant and refugee women, in particular, face severe marginalisation when seeking antenatal care, a situation exacerbated by COVID-19 (Orcutt et al., 2020). Whilst fleeing severe disasters, crises, gender-based violence or persecution, migrants and refugees experience higher risks of precarious sanitation and safety conditions during transit and in places of abode (Riggs et al., 2017); they may face prohibitive costs of maternity care because of lack of citizenship or employment rights, or might be unable to find appropriate information about family planning, antenatal care, access and transportation to clinics because of lack of familiarity with the host country; they may also experience mistrust in the health care system, fear of stigma, or other cultural barriers (Pilato et al., 2021). Similar difficulties in accessing suitable antenatal care services, health promotion resources and an appropriate professional network of support, particularly fragmented during the pandemic, have been experienced by adolescent girls (Lokot & Avakyan, 2020), women from low socio-economic status, and ethnic minorities (Esegbona-Adeigbe, 2020). Supportive caring relationships free from violence, access to family planning, appropriate health and social services when needed, healthy nutrition, safe housing and sanitation services, sufficient income, job security are all crucial factors that impact pregnant women and new mothers’ health, well-being and long-term outcomes (Sandall et al., 2024; Vedam et al., 2022). Securing equitable and appropriate care for women during the perinatal period is salient at the individual but also at societal level, as early childhood is crucial in influencing new generations’ social and educational outcomes (Laurenzi et al., 2020).

However, tailoring adequate care to highly specific needs can become a highly complex challenge for health systems (Higginbottom et al., 2019; Koblinsky et al., 2016; McLeish & Redshaw, 2019), even a wicked problem (Dahlen et al., 2022; Gamberini et al., 2023), with no straightforward root cause or standardized solution. The very definition and understanding of vulnerability itself are value-laden (Angeli, Camporesi, and Fabbro 2021), situated in highly idiosyncratic contexts and subjective to individuals’ lived experience. Even in high-income settings, with the presence of trained professionals and adequate health infrastructures and delivery systems, the uptake of antenatal and postnatal check-ups among vulnerable pregnant women (such as ethnic minorities, asylum-seekers and migrants) is still far from satisfactory, with disproportionately negative impacts on maternal mortality and morbidity and on the long-term health of the infants (Brown et al., 2014; Galle et al., 2015; Phillimore, 2016).

Against this backdrop, how can policy and practice then devise models able to improve the uptake and effectiveness of maternity care among vulnerable groups? This article tries to unpack this question by building on socio-ecological and intersectionality theories. An intersectional view is particularly well-placed to help understand how vulnerable pregnant women - hence those who are ‘are threatened by physical, psychological, cognitive and/or social risk factors in combination with lack of adequate support and/or adequate coping skills’ (Scheele et al., 2020: in Van Blarikom 2022: 1) experience disadvantage (Lokot & Avakyan, 2020; Walby et al., 2012). However, the multilayered, dynamic nature of inequity they experience and the shifting and contextual nature of their vulnerability need an intersectional discourse that moves beyond the foundational triad of gender-class-race (Mohanty, 2013; Rodriguez et al., 2016) or the static perspective offered by Acker’s concept of inequity regime (Acker, 2006). We therefore propose an expansion of intersectionality thinking through the socio-ecological framework (Angeli, Jaiswal, and Shrivastava 2022; Bronfenbrenner 1977) and we use this to guide our quest for fresh understanding of maternity care delivery to vulnerable women. This novel theoretical approach allows for appreciating individual subjective lived experience of vulnerable women – in the tradition of intersectional work and epistemology – by investigating how healthcare professionals, such as midwives, experience the intersectional disadvantage of the women they serve and attempt to redress it through the promotion of ground-up organisational change.

Through a single case study research design, this study explores how midwives operating in a midwifery group dedicated to vulnerable women – the HAAMLA team in Leeds, UK – conceptualise vulnerability, identify women’s needs and alter care delivery systems to address the specific circumstance of their patients through an adaptive and collaborative care model organically developed over time. Increasing evidence highlights that supporting midwifery and midwife-led continuous care models of maternity service is crucial to provide adequate care to women, particularly from vulnerable groups, both in high-income and low-middle income countries (Dahlen et al., 2022; Fernandez Turienzo et al., 2021; Rayment-Jones et al., 2021; Sandall et al., 2024).We aim to advance this line of work and contribute to practice by looking at the processes leading the healthcare professionals to co-produce care together with women and external actors, which appear salient to achieve adaptive, women-centred models. This study therefore asks: *how can professionals dynamically adapt maternity care delivery to cater to the needs of vulnerable pregnant women?*

Before we move into the theory section, it is important to clarify that our use of ‘women’ and ‘mothers’ – which we chose out of efficiency and consistency with the literature (e.g. van Blarikom et al., 2022) – can and should extend where applicable to (trans)men or people who consider themselves non-binary and who are pregnant.

**THEORETICAL BACKGROUND**

**Understanding vulnerability of pregnant women: an intersectional, socio-ecological view**

Intersectionality as a concept was first introduced by Kimberly Crenshaw in 1989 (Crenshaw, 1989) and stems from feminist scholars’ early recognition that dimensions of social life, and related social categories, are inherently interdependent, and jointly shape the unique and complex lived experience of disadvantage and social exclusion (Atewologun, 2018; Mandel & Semyonov, 2016; Walby et al., 2012). The intra-categorical perspective of intersectionality generates from the need to better understand relevant differences between individuals within groups that have previously been considered as largely homogeneous (for example, women, black people, migrants) and hence to study otherwise neglected intersections of social categories (Healy et al., 2019; Kapilashrami & Hankivsky, 2018). The inter-categorical approach of intersectionality instead is concerned with between-group differences and power dynamics – also known as ‘inequality regimes’(Acker, 2006) - leading to systemic inequity (McCall, 2008). Together, the intra- and inter-categorical perspectives theorize the multiple layers of social exclusion based on the individuals’ social position at the intersection of micro social categories and in relation with macro social structures (Atewologun, 2018). However, whilst the intra-categorical intersectional view has been widely explored and applied, the interplay between individual subjectivities and contextual, macro factors has received less attention. Holvino (2010) in particular calls for the ‘contextualisation of subjectivities within structures and institutions and argues that individual narratives, organizational practices and wider societal processes must be explored in an interconnected way in order to destabilize dominant organisational discourses and challenge the power dynamics that sustain system of inequalities within organisations’ (cited in Rodriguez et al., 2016: 203).

Addressing this gap, the socio-ecological view adds to intersectionality theory by further specifying the nature of social institutions and the relevant levels of analysis that shape the interactions of social identities and lead to intersectional disadvantage. Socio-ecological thinking roots back to Bronfenbrenner (1977) and has been then extended and refined through its application in different domains, for example to design health promotion initiatives (Mcleroy et al., 1988), to explain health-seeking behaviour for prenatal care (Sword, 1999), to study food choice in schools (Moore et al., 2013), to guide interventions tackling social inequality or to examine comprehensive social change dynamics (Costanza, 2014), and also to understand menstrual hygiene and health in resource-constrained settings (Angeli, Jaiswal, and Shrivastava 2022). In its most common formulation, the socio-ecological model explains individual behaviour through the dynamic interaction of different sub-systems, namely intrapersonal attributes (i.e. characteristics of the individual, including education, employment, skillset, attitudes), interpersonal processes (i.e. interactions within formal and informal social networks and groups), institutional factors (i.e. social institutions and organisations that define formal and informal rules and norms), community factors (i.e. relationships among institutions and informal networks) and public policy (macro laws and policies). By considering how individual subjectivity and lived experiences co-evolve with institutional and contextual factors, an intersectional, socio-ecological thinking helps illuminate why some women may face risks and experience vulnerability in their physical and mental well-being during their pregnancy and in the perinatal period, some of which will inevitably impact on the foetus/infant, whilst others may not, despite their context. Moreover, it can help identify new organisational models that redress intersectional disadvantage by altering interdependencies across levels of analysis that produce vulnerability and inequity. Figure 1 highlights the proposed intersectional, socio-ecological perspective adopted in this article.

-------------------------------------------

Insert Figure 1 about here

-------------------------------------------

**Organizational change and network governance for complex health delivery**

This study will particularly zoom in two aspects of the socio-ecological context where women are embedded in: the organisational and inter-organisational spheres. The former looks at how the relationship of vulnerable pregnant women with midwives and healthcare professionals shape dynamics of disadvantage. Brown and colleagues (2014) highlight the difficulties experienced by care providers in dealing with situations characterised by intertwined issues – such as low literacy levels, domestic violence, single parenthood, poor housing, unemployment – which would require longer appointments to meet individual needs and address co-morbidities (Brown et al., 2014; Fiscella & Shin, 2005). On this vein, and recognising increasing inequities of maternal care outcomes due to inadequate delivery processes, the UK government has recently set up a task force to improve personalised care to vulnerable groups, through better collaboration between the Department of Health and Social care and other governmental departments, with the aim to empower women and improve access (Department of Health and Social Care, 2022). Yet, knowledge is still very limited on whether and how professionals on the field are able to cater to the needs of vulnerable pregnant women and how they engage with other organisations to coordinate collaborative maternity care pathways. As a result, evidence of alternative delivery models of care that re-conceptualise maternity care around vulnerable pregnant women is still scant.

Important is also the interdependence between women, healthcare professionals and the larger support system around vulnerable groups, which requires the governance of a complex network of partners and organisational actors, also across sectors. Collaborative models and network-based coordination mechanisms are increasingly seen as alternative forms of organizing to tackle complex environmental and social challenges (Raab, 2022). Shared governance networks are widespread and increasingly adopted among healthcare and social services (Provan & Milward, 1995), as they are often intended as an important way to build and create "communities" (Cristofoli et al., 2014) and to ensure continuity of care, especially for patients with long-term conditions and complex co-morbidities. Remarkably, recent health policies in Western countries are rapidly promoting a shift towards collaborative partnerships to address increasingly complex healthcare pathways and reduce inequalities, as in the case of the recently introduced Integrated Care Systems in the English NHS (Anderson et al., 2022). However, no studies so far have investigated the dynamics of network governance for maternal care, despite calls for advancing the knowledge and improving the practice around the integration across health-care services and between different levels of care for better maternity care (Koblinsky et al., 2016). Klode and colleagues have observed the tensions and difficulties arising from interprofessional and intersectoral collaboration around vulnerable pregnant women, often stemming from different perceptions of vulnerability even within the same profession but across sectors, as in the case of social workers (Klode et al., 2020). Yet, how different actors are activated and self-organise around the needs of vulnerable pregnant women, and whether and how this process evolves with the growing understanding of the multifaceted, intersectional, and subjective conceptualization of vulnerability, has not been examined.

**DATA AND METHODS**

Given the exploratory nature of this study, and its objective to represent the social processes and lived experience underpinning HAAMLA, we followed a qualitative approach, based on a single-case study design (e.g. Vestergaard et al., 2021). Following a naturalistic case study approach allowed for an in-depth exploration able to emphasize the ‘particular’ and the relevance of the context (Abma & Stake, 2014), and to underline the organic, situated, multifaceted aspects of social dynamics and interactions (Stake, 2000), evolved between vulnerable women and their midwives in the HAAMLA team over time.

**Empirical setting**

HAAMLA is a specialized community midwifery group of the Leeds Teaching Hospital NHS Trust, in the English National Health System (NHS). The English NHS is funded mainly through general taxation and through the UK government (Anderson et al., 2022); in 2020/21 the Department for Health and Social Care spent £192 billion to cover a wide range of health and care services, including GP services, ambulance, mental health, community and hospital services, part of social care services and public health (King’s Fund, 2022). In this complex healthcare system, NHS trusts are responsible for the delivery of specialised care and of maternity care, which comprises antenatal, postnatal and during birth care and support. Maternity care starts as early as the women realise they are pregnant; they are recommended to get in touch with their general practitioners and make an appointment with their local community midwife before the 10th week of pregnancy. A usual antenatal care pathway is composed of up to 10 appointments and at least two ultrasound scans, in addition to screening for genetic conditions or blood diseases and blood testing.

**Data collection and analysis**

This study relied on both primary as well as secondary data. Primary data collection involved the whole HAAMLA team and was carried out through 6 semi-structured interviews – conducted between June 2022 and March 2023 – with 7 HAAMLA team members: four midwives, the team leader, the community midwifery matron, and one support worker, all with different levels of seniority and tenure within the team (a table with interviewees’ characteristics is omitted here as it would potentially violate confidentiality). For example, one midwife had 36 years’ experience of midwifery work and had worked 12 years of within HAAMLA; she has talked to us just months before retirement. Another respondent had practiced midwifery for 7 years and joined HAAMLA only four months before the interview. All interviews were held via Zoom (to comply with COVID-19 regulations still in place at the time of the interviews), lasted an average of 47 minutes each, for a total of 4 hours and 45 minutes of material. With the consent of the participants, the conversations have been recorded and transcribed verbatim. Only one support worker and one very recent recruit of the HAAMLA team did not take part in the interviews; the primary data collection therefore covers almost the entirety of the team and can be considered as highly representative of their work. This was also validated through a saturation rationale, as no new themes emerged after the first four interviews.

To complement and triangulate the first-hand information and historical recollection that were provided during the interviews, a total of 20 archival documents and publicly available reports were identified through an online search and consulted. These included the Leeds Teaching Hospital NHS Trust annual reports, power point presentations on HAAMLA provided by former midwives and team leaders and available online (e.g. Khan, 2013; Leeds Teaching Hospital NHS Trust, 2014, 2023), policy and practice-oriented reports, such as the Leeds Maternity Health Needs Assessment (Goldsborough, 2020) and the State of Women’s Health in Leeds report (White et al., 2019)grey literature and academic project reports, for example the Leeds Beckett final study report (Warwick-Booth et al., 2018). Dedicated scientific literature (e.g. Bennett & Scammell, 2014; Evans et al., 2022; McKnight et al., 2019) as well as newsletters provided additional background information sources. This body of archival, secondary data allowed for cross-checking and complementing the information received during the interviews, particularly around the original setup of HAAMLA, its vision and development over time. To ensure truthfulness of the researcher’s interpretation and recounting, the final manuscript has been read and approved by HAAMLA’s leadership and project participants, according to a procedure of member checking.

Data analysis of qualitative material – both primary and secondary – relied on the three-step methodology advised by Gioia et al (2013) and carried out via NVivo software. We used an abductive approach to data analysis, where the theoretical framework informs the analysis and interpretation of the data but the coding remains open to new and surprising findings that may extend or modify the underlying theories (Ward et al. 2016). The material was therefore openly coded and first-level constructs identified. A total of 156 segments were coded in this phase, then aggregated in 22 second-order codes. These were in turn aggregated in 5 higher level categories, informed inductively but also influenced by the intersectional socio-ecological theoretical framework guiding this study. As such, they consider individual, organizational, interpersonal and systemic factors. The final categories related to: HAAMLA team’s unique model and its evolution over time; vulnerability as a unique lived experience; holistic and bespoke maternity care delivery; trust-based relationship building; and woman-centered, adaptive network activation. The following result section will present these categories. Figure 2 represents the coding tree, whilst the code book, with more details on the coded segments and the number of segments coded per each category can be found in the supplementary material (Appendix).

-------------------------------------------

Insert Figure 2 about here

-------------------------------------------

**Rigor and reflexivity**

A researcher’s critical account of their position with respect to the research and knowledge production process of paramount importance in ensuring the rigour of qualitative research (Rankl et al., 2021). The researcher conducting the interviews and first author of this article had no prior knowledge of or relationship with the interviewees. However, as a mother and an immigrant, she experienced giving birth in a country different than her native one and had to navigate language barriers, unfamiliar maternity care model as well as socio-cultural differences in approaches to and perception of childbirth and motherhood. This personal background, also shared by another co-author on the article, has allowed her to deeply empathize with the difficulties described by the midwives and to appreciate their efforts in providing specialized services to vulnerable pregnant women. This empathetic stance created a ‘safe space’ where the interviewees felt comfortable and encouraged in sharing their and their patients’ experiences (Zhong et al., 2024). This research positionality could however have also created a bias in the interpretation of the qualitative material, by clouding objectivity and colouring both the understanding and the presentation of the findings with the researcher’s affect and experience in relation to pregnancy and childbirth in vulnerable and unfamiliar circumstances. The thematic analysis has therefore been conducted abductively – hence informed by existing theory – and cross-validated by both the interviewees through member-checking and by a third co-author, who shares an immigrant status but not the experience related to childbirth.

**Ethics**

The study has obtained ethical approval from the Health Research Authority and Health and Care Research Wales. Through a dedicated participant information sheet, the project participants were informed of the project aims and structures, of the prospective use and protection of the collected data and of their right to decline or withdraw participation within four weeks after the interview had taken place. The ethical approval process also required that all participants provided informed consent and agreed to their interview being recorded and transcribed for the purpose of data analysis. All research data were anonymised and only professional roles are indicated in the quotes. We however sought specific and additional authorisation to use the actual name of the team – HAAMLA – given that the small sample size might make anonymisation less effective in protecting anonymity.

**RESULTS**

**The Haamla team’s unique midwifery model and its evolution over time**

HAAMLA means ‘pregnant’ or ‘with child’ in Urdu and Arabic languages. Recognizing the specific needs and higher risk of adverse outcomes of pregnant women from Black and Minority Ethnic groups in the city of Leeds, West Yorkshire, UK, the HAAMLA team was launched by Leeds Family Health Service Authority (FHSA) in 1994 and mainstreamed in 1997 as part of the Maternity Services at Leeds Teaching Hospitals NHS Trust. The Black and Asian population minority population in Leeds registered an 83% growth between 2001 and 2011, rising to 14.9% and to 21% of the population in 2011 and 2021 respectively (Bennett & Scammell, 2014; White et al., 2019) This rapidly changing demographic, combined with the mounting evidence of over-representation of non-White ethnic groups in cases of stillbirths and maternal deaths, led to the rapid growth of HAAMLA, with the aim to improve access and outcomes of maternity care, by informing and empowering women to make informed choices; complementing the care received by the hospital and community service; increasing breastfeeding rates and reducing infant mortality among Black and minority ethnic women (Presentation ‘What is Haamla’ Leeds Teaching Hospital NHS Trust, 2014; Warwick-Booth et al., 2018).

HAAMLA’s population focus, and the scope and nature of its services substantially evolved over time. From an initial focus on ethnic minority women and their needs through advocacy and support, HAAMLA team expanded to include formal midwifery care in 2010. Today, HAAMLA services cater to vulnerable women as a broad category. An initial referral checklist highlights the main categories in need for HAAMLA midwifery caseload as: Asylum Seeker; Isolated Refugee (less than 1yr in UK); English/Irish Gypsy Traveller; Spouse/Family Reunion; Domestic Violence; Homeless; Other vulnerable ethnic minority groups; Non English Speaking; New Migrants; Overseas Students; 1st Pregnancy in UK or 1st child born in the UK (Bennett & Scammell, 2014; Presentation ‘Making Change Happen’ by Khan, 2013). The advocacy and support services offered by HAAMLA include antenatal groups and classes; social/emotional support; home visits: antenatal and postnatal care; breastfeeding support. The service is culturally sensitive, tailored to the women’s needs, and often relies on the use of trusted, professional interpreters who regularly work with HAAMLA, both during home visits and in antenatal groups . Before the pandemic, HAAMLA also delivered Doula services, with volunteered certified doulas who offered emotional and physical support to women during the antenatal and postnatal and through birth (Balaam et al., 2016; Leeds Teaching Hospital NHS Trust, 2023). Over time, HAAMLA has developed the expertise to deal with complex cases of female genital mutilation (FGM), particularly present among women coming from central Africa, and Eritrea more recently.

*‘We initially started more from a community support, advocate support, through outreach workers and stuff. And then when we took it on in the trust, we employed an administrator who did the admin side of that, support workers and then midwives. So although it's only still a small team, what they do has grown quite a lot over the years. And we also run alongside that midwifery service, our FGM service as well. So the midwifes are trained in the FGM.’ (Community Midwifery Matron)*

HAAMLA’s model has grown along the increasing recognition of what women need, through a two-decade long co-evolutionary process. Importantly, HAAMLA as a team – composed by both midwives and support workers - has evolved also to act as a linking pin among many different organizations (e.g. Home Office, charities working with refugees and asylum seekers, FGM clinics, social services, children’s centres, the police, food shelters, housing services, community groups, interpreters, specialized healthcare providers, etc) that coordinate to address the often highly specific, intersectional needs of vulnerable women, from referral to the postnatal care. This crucial signposting activity requires working in a multidisciplinary, highly adaptive way – a unique capability that HAAMLA as a team have developed over time and that characterizes its unique organizational model.

This approach is perceived to be highly effective, which is a strong propulsor of midwives’ motivation and satisfaction to work in the team.

*‘It blows my mind that it is not standardized care, especially because of what we know. We know that women, Black and minority ethnic women are so much more at risk of adverse outcomes in maternity. This should be the answer, it should be minimum what we're doing to help improve the outcomes for the women that we look after’. (Midwife)*

*‘And it really works. When you look at our outcomes, touch wood, they're really good and we give women good continuity and we're able to build that relationship and hopefully improve their outcomes. So I do feel like it is changing’ (Midwife)*

This type of care and services requires very specific expertise and training. HAAMLA team recognises the relevance of learning on the job, as dedicated training programs are limited and difficult to design (‘*it’s a hard job to teach’ ‘it was actually a massive learning curve for me’ - Midwife*). Although the work is recognized as very fulfilling and rewarding and the possibilities to work with vulnerable women is often defined as ‘a dream’, a ‘privilege’ and a ‘passion’ (*No one day's the same and I think that it's the best team to work in, in my opinion, it's my passion – Team Lead – it's my dream – Midwife 1*), HAAMLA team also highlights the emotional toll incurred whilst caring and addressing the needs of vulnerable women, which requires dedicated support for the midwives and support workers involved:

*‘Yeah, it's hard. There's a huge amount of emotional trauma really that comes with that for our women and that's difficult. That's definitely something that we have to learn to do, I think, and are always learning. It's very difficult not to take that home and take it all with you. I think for some women it's more easy, we learn to do that, okay, but there are definitely certain women whose stories really stick with you and really do affect you.’ (Midwife 1)*

*‘The things you hear, you've never heard the likes before and it's very difficult. And that's not for everybody to work with someone like that day in, day out, it's really difficult.’ (Community Midwifery Matron)*

**Vulnerability as a unique lived experience**

The concept of vulnerability – in the perception of midwives and from the dedicated, practice-oriented literature consulted (Balaam et al., 2016; Bennett & Scammell, 2014) – widely emerges as a socially constructed, intersectional category, for which the intake checklist only provides a starting point. Once a pregnant woman is referred to the team, a conversation always follows to understand the specificities of her lived experience and of her potential disadvantaged circumstances in dealing with her pregnancy within her context.

*‘They just come with additional needs or complexities that put them at a disadvantage, I suppose. So that might be access to care, access to maternity care. So women who are new in the UK who don't understand the maternity system, how that works, how to access care. It could be women who are living with other complex issues like domestic abuse, victims of trafficking, women who are homeless, just women that for us, women that really have additional needs that impact their access into maternity care.’ (Midwife 1)*

Cultural differences and different experiences of healthcare systems are often a strong barrier to antenatal care access in the UK, as in the case of Afghani or African women.

*‘They might not be accustomed to accessing maternity care in the countries that they come from so we have some tribal African women who don't know what a hospital is, so they're just used to village elders and stuff doing their care so it's just about supporting them to trust us in the same way that they'd trust their elders.’ (Midwife 4)*

The advocacy and information activities put in place to overcome information gaps and cultural differences are particularly salient when it comes to FGM cases:

*‘So the FGM service is looking after women with female genital mutilation. So we identify women at booking when we do a risk assessment, if they've been circumcised, we invite them all to our specialist clinic where we see four antenatal women a week. And in that appointment we discuss FGM safeguarding, we talk about the law around FGM and then we offer the women an examination and that's to identify the type of FGM that they've had, but also to make a plan for a safe delivery of baby to make sure there's not any concerns for delivery.’ (Team Lead)*

Sometimes, the identification of the woman’s needs is a complex process that requires multiple home visits and conversations, as the women themselves might not be fully aware of their own disadvantaged situation or might not want to be included in the care of a special midwifery team. Talking to them and visiting them at home is perceived to be crucial to gauge a full picture of their situation:

*‘So basically, for midwifery care would be an asylum seekers, refugees who are under one year in UK, English, Irish, gypsy travellers because they move a lot. Any ladies who are on a spouse visa, reunion visa, domestic violence, homeless and any vulnerable Black and minority ethnic groups. But this also can vary because some, for example, asylum seekers, they may say, no, we don't want to be, we want to be with our midwife, but if we need any extra support, we will get back to you. And we are happy to do that in some cases. So we do talk to all of them but sometimes you have to ask women, would that benefit them?’ (Support Worker)*

There are cases that might require *‘a little investigation’* *(Support worker)* as complex circumstances of disadvantage might emerge over time, like *‘a puzzle coming together’ (Support worker)*. Identification of these cases requires experience, expertise, focus, attention to details but also ongoing conversations among midwives and support workers, to develop a collectively validated understanding and interpretation:

*‘So it's interesting. Sometimes, we meet people and it's an ordinary woman and suddenly kind of a puzzle from different areas comes up together. We do also talk a lot in Haamla. We communicate a lot, which is like, we need that because everybody's got a little bit of difference. Everybody can investigate, a little investigators there.’ (Support Worker)*

The midwives and support workers in the study recall a variety of complex cases, including women that were trafficked without their knowledge, women pregnant with their second or third child, having to care for the rest of their family whilst fleeing from a conflict in their home country and navigating the complexity and requirements of asylum-seeking, women victims of domestic abuse, initially extremely reluctant to discuss any aspect of it but then becoming very dependent on the midwives’ support.

**Holistic, trust-based relationship building at the heart of maternity care delivery**

The intersectional and socially constructed character of vulnerability as depicted above requires an approach that is highly adaptable and responsive to each woman’s specific needs. The midwives and support workers unanimously speak about ‘holistic care’.

*‘So it is a total different way of working that is focused around the woman, the family, and the needs. Sometimes they do have to come into the hospital because obviously they'll need to be seen by an obstetrician or our FGM clinic is obviously based in the hospital just because of the nature of that clinic. But the midwives or the support workers spend a lot of time understanding, sometimes they'll let escort them into the hospital with them or if they've got other children they'll kindly look after the children while they're in with the doctor and things like that, so it's very bespoke, very individualized, each woman might be slightly different. So although like XX says, we have a criteria to women that we do see, within that there's so many other variations of what actual care that woman needs because no two women really... Other than the official process of asylum, pretty much everything else is very individual to their needs.’ (Community Midwifery Matron)*

A crucial aspect of the service is home visits, which can last for as long as necessary and are considered crucial to develop a bond with the woman whilst appreciating her living conditions and family circumstances (‘*we have a lot more time with them. So really we can spend as much time as we need or they need with us’ – Midwife 1*).

Striving to establish a deep, trust-based bond with the vulnerable pregnant women under HAAMLA’s care is a very important aspect of their model. Hence the relevance of home visits, which allow for a deeper understanding of the women’s circumstances but also for the nurturing of a much closer relationship, face-to-face and within the context of their family, between the midwife and the woman. During the COVID-19 pandemic home visits were severely restricted, which prompted the midwives and support workers to further appreciate and underline their importance:

*‘I think [the pandemic] really highlighted the importance of us being able to be in women's homes, from a perspective of the Haamla Service, because it just gives so much more of a holistic care. And I think it really just showed us we really need that. We really need to be in these women's homes. We need to be with them to build that relationship and see them and provide the care that we do.’ (Midwife 1)*

The body language and the face-to-face contact and presence, of both midwives and interpreters, are considered as salient to the establishment of a trusted relationship, which is three-way: between the midwives and the interpreter, the midwife and the woman, and the interpreter and the woman. In this context, interpreters clearly play a crucial role – the woman needs to trust them, to relay their words and their deeper meaning in a truthful way, as well as the midwife, who relies on them entirely to communicate with the woman and gauge her needs, values, fears, concerns.

*‘And I think that is paramount for us as professionals that there's that trust level. Because when I'm doing telephone interpreting, I'm aware that people might be at home cooking the tea and then their whole attention is not necessarily on the interpreting.’ (Midwife 3)*

The interviewed midwives perceive these relationships to gradually grow very important to the women, who seem to develop emotional attachment towards the midwives and come to trust them as family members, well beyond their pregnancy time.

*‘I've got women that I looked after when I was just a midwife in the team that still contact me, send me pictures, they want to keep in regular contact with you because like I said, they think of you as part of their family, you're part of their life, you've provided this care for them and they don't want to lose that bond.’ (Team Lead)*

**Bespoke support through a woman-centered, adaptive network activation**

The understanding of vulnerability as subjective and intersectional enables the midwives to activate a wide network of partners to ensure that the pregnant women’s needs are catered for, the understanding of which is cemented by the trust-based relationship established with the women themselves. The need and capability to coordinate the network of agencies along the woman’s pathway is idiosyncratic to HAAMLA’s unique organizational model and constitutes a key point of differentiation in the type of care and support they deliver to vulnerable women, with respect to traditional maternity care and midwifery services. The network activation starts with the case referrals:

*‘So we get referrals from domestic violence, women's refugees from an agency called PAFRAS, that we work quite closely with, which it stands for Positive Action for Refugees and Asylum Seekers. So if they have asylum seekers that come through that they know are pregnant, they'll refer to us. The Red Cross, we get referrals from and also from other. Obviously with asylum seekers there's quite a lot of movement. They might be moved by the Home Office, so we might get referrals from other areas within the UK that know women are coming in into Leeds and they might refer directly to us. And some women we've cared for before and they refer to us, they just get in touch with us directly and refer themselves back to us.’ (Midwife 1)*

The intersectional nature of women’s disadvantage and vulnerable conditions also means that multiple services might be needed at once and mobilized based on the woman’s specific needs.

*‘‘There's a lady who's an asylum seeker who's pregnant with twins at the minute. So obviously, the twin team are more specialists in supporting women who are pregnant with twins. But obviously we can help because she's an asylum seeker. So the nadir in our team is doing shared care with the twin team.’ (Midwife 2)*

*‘Obviously lots of the asylum seekers we see and refugees, they have PTSD and depression, so it does cross over with [mental health midwifery teams] quite a bit.’ (Midwife 2)*

Then there are support services such as multilingual antenatal groups, housing advice, and provision of goods. Coordination also occurs around antenatal classes, which cater to various groups of women and are delivered by HAAMLA’s support workers and dedicated interpreters. Antenatal classes provide a very rounded picture of women’s experience and needs that go beyond their pregnancy specifically, which support workers try to address through their knowledge of through their networks. General support and advocacy services are also important, whenever needed, and the signposting to other organisations, to create a support network:

*‘And we work very differently because as well as providing normal antenatal care, we're also liaising with lots of other charities, organizations, lots of safeguarding, food banks, children's centers, and we're just giving them more support. So for example, if I was looking after woman in a normal GP clinic, I might tell her about a whooping cough vaccine and she would go off and book that herself. Whereas for lots of our women, they need us to call and book that. They need us to tell them where appointments are. Just a lot more additional support for them.’ (Midwife 1)*

*‘So kind of building that little circle of people around them.’ (Support Worker)*

Typical network activation mechanisms also happen when midwives perceive safeguarding issues, such as potential for trafficking or domestic violence. The natural partners in this sense would be the police and social workers, however the situation is often complicated by the fact that the women themselves might not perceive danger.

*‘And it's that body language and them being scared, that is helpful. And the problem is they sometimes feel very safe with these people. They're introduced to them. There was another woman who came from Greece who had come via Italy, which is a common route for Romanian to come out. Her only person she knew who she called a friend was a Bulgarian or Romanian speaker, and she felt safer being with her than going to a place of safety.’ (Midwife 3)*

Another type of network activation is around support of migrants, who require liaison with several governmental agencies and third sector organisations:

*‘Yeah, migrant support. We've got lots of different avenues we can turn to for help, Ashiana, they look after women who've been trafficked. So there's lots of different avenues we go down to give these women additional support and so we ensure that they've all got the necessary equipment for the babies. We provide them with packs, with Moses baskets, clothing, nappies, everything they need really, push chairs we can get, 'cause we know that they can't get these items themselves. So we do quite an enhanced package really and it's all done in their own homes.’ (Team Lead)*

Another sub-group requiring a different support network relates to the refugees, which demand particular attention to housing issues, legal and welfare aspects:

*‘We work with RETAS, which is Refugee Education Training and Support, which is a locally based organization. The Refugee Council, particularly with relation to the Afghans, and some with the City Council. We get involved with housing, welfare rights and benefits, although that's mainly our support workers, but also we can sign posts towards English classes.’ (Midwife 3)*

Attention is also posed to mental health challenges, which require yet another type of referral or arrangements with other agencies, such as the Perinatal Mental Health Service.

Talking about their relationships with the various charities and agencies, one support worker said:

*“And it works perfect. I would say we are more like a link support workers… [our partners] very open and advising us, and if we don't know something, we do also ask them because they may know things and there is so many new things happening and changing and new establishments, people like supporting with food puzzles and baby items. I have antenatal class with outreach workers from children's center. So I find out that speaking to them even give me some kind of ideas we're sharing between us, we share what they use in the area because areas of Leeds may have a little bit different kind of support and links and it's more local for the clients. So we try to contact them first and see if they can take it over from us, if they can.” (Support Worker)*

Figure 3 depicts the model of relationships between all the emerging constructs and highlights how the type of holistic care model provided by HAAMLA midwives relies on the understanding of vulnerability as a subjective, socially constructed, and intersectional category, which in turn helps midwives develop a trust-based, non-judgmental relationship with women and enables them to activate an appropriate support network, addressing their case-specific needs. The findings highlight how the HAAMLA team have developed over time two unique *relational dynamic capabilities -* adaptive network activation and trust-based relationship building. These therefore are geared: 1) towards the women, by nurturing the development of a trust-based, long-term relationship through home visits and tailored appointments, which in turn informs and feeds in the concept and understanding of vulnerability and consequently improves the characteristic and modalities of the bespoke, holistic care that midwives deliver; and 2) towards the larger support network, by progressively activating partners in a way that is woman-centred and adaptive. This approach results in network governance choices that are tailored on the needs of the specific case, where virtually every woman comes to rely on a unique support network around her. In turn, these network activation processes enable growing reciprocal knowledge among partners through the exchange of expertise and experiences, which refines the understanding of vulnerability within the broader network and further enriches the accuracy and effectiveness of the care provided. These two relational capabilities are therefore dynamic in a way that unlocks a learning mechanism: developing and refining these capabilities co-evolves with the increasing understanding of vulnerability and the provision of bespoke, holistic maternity care that is tailored to women’s needs, in a virtuous cycle of systemic improvements and care co-production – with both the women and the external partners.

-------------------------------------------

Insert Figure 3 about here

-------------------------------------------

**DISCUSSION AND CONCLUSION**

**Theoretical contributions**

The work advances the rich body of literature on intersectionality and intersectional disadvantage, traditionally born within the feminist tradition (Atewologun, 2018; Kapilashrami & Hankivsky, 2018; Walby et al., 2012). First, it embeds intersectional subjectivities and lived experiences of inequity into structural and systemic dynamics, by highlighting the interdependences and co-evolution between individual and higher-level organisational and inter-organizational factors. The HAAMLA case and the evidence emerging from the interviews confirm how the very concept of vulnerability and disadvantage are socially constructed and vary at the intersections of highly specific social categories to create unique predicaments. The findings highlighted cases of non-English speaking, Eastern European pregnant women being trafficked without their awareness, and ending up couch surfing; women from black and minority ethnic groups, pregnant with their second or third child and falling victim of domestic violence, who were reticent to press charges at first and then moved to safe houses or communities. Asylum-seeking, non-English speaking women, unaware of how pregnancy was affecting their bodies and of how their health and well-being affected the development of their infants, completely unfamiliar with the English healthcare systems and hence entirely unprepared to even recognize the importance of maternity care; Eritrean or African women from other geographical origins – who suffered from FGM - who were used to only village elderly advising on their health, and who were entirely unaware of the consequences of FGM for their physical and mental health and the one of their unborn or newborn children; pregnant Afghan or Ukrainian refuges, often isolated form their families and potentially suffering from PTSD. These cases document how not only ethnicity class, gender, and income play a role in configuring inequity, but also education, housing, food security, the presence of a friend and family support network, the community values, the gender and family dynamics at home, the interactions with the health and social care systems and with the wider policy framework. Intersectionality theory in this work is therefore enriched by a socio-ecological framework to enable a more nuanced understanding of inequity, where individual factors interlock in often unexpected ways with environmental constraints and opportunities – at different scales – to exacerbate or mitigate disadvantage and vulnerability, over time.

Second, this research advances the organizational body of literature on dynamic capabilities, as they emerge as key to translate evidence into concrete interventions. HAAMLA illustrates how intersectional understanding of vulnerability has shaped over time an effective and innovative organizational model for the delivery of maternity care to vulnerable groups, able to mitigate inequity and redress situations of disadvantage. The case represents a starkly new organizational model, which evolved through an organic, need-driven, bottom-up process and through two key *relational dynamic capabilities* that midwives have developed over time: one focused on trust-based relationship building and one on woman-centered adaptive network activation. These relational dynamic capabilities are crucial as they connect individual subjectivities to higher-order systemic dynamics. The concept of dynamic capabilities is in fact not new to the management and organization studies literature, with a long theoretical and empirical tradition dating back to Teece and colleagues (1997). However, *relational* dynamic capabilities, despite being recognized as salient in the context of alliance management (Dyer & Kale, 2007), have remained understudied, with only a few exceptions. Borrowing the definition of Donada et al (2016), we define relational dynamic capabilities as *the ability to integrate, build, and reconfigure a set of skills, assets, and routines that provide the basis for new and dynamic organisational models able to address changing needs and environments and redress inequity*. We therefore highlight adaptive network governance and trust-based relationship building as crucial relational dynamic capabilities of the HAAMLA model, enabling the team to continuously adapt the type of care provided and ensure holistic and bespoke service to their women.

Finally, the article findings also advance existing research on collaborative practices and network governance (Klijn & Koppenjan, 2016; Provan & Kenis, 2008; van Duijn et al., 2022). The ordinary delivery of maternity care towards vulnerable women is a systematic, ongoing process which however cannot be standardized because of the highly idiosyncratic characteristics of women, leading to - and stemming from - situations of intersectional disadvantage. The network of partners involved in the maternity care delivery span across third sector organisations (e.g. Red Cross, Positive Action for Refugees and Asylum Seekers - PAFRAS, Leeds Asylum Seeker Support Network - LASSN, Refugee council, and several local organisations), public bodies (e.g. Home Office, City Council, the police), healthcare providers (Perinatal Mental health service, specialized mental midwives, gynecologists, Children’s centres FGM clinics, GPs and community midwives groups), social workers and support workers. Given the different areas of expertise of these partners, the resulting network can be considered as governed by a participant-shared rationale, without any organization taking a formal lead, but with the partners instead coming together for a shared purpose (Nowell & Albrecht, 2023). Literature so far however has not achieved in-depth understanding of the coordination mechanisms regulating these networks and particularly how they unfold at individual level. Network governance work has focused on emergency-driven network formation processes (Koliba et al., 2011) or on governance types at systemic level (Romiti et al., 2020) but has left aside micro-founded mechanisms of collaborative work within networks. This case highlights how not all network partners contribute to the goal or coordinate at all times, but instead it is the specificities of the goal at hand that drives a form of adaptive and temporally bounded coordination. In this specific type of network governance – which could be called *goal-led network activation* – partners strengthen and improve over time their reciprocal knowledge and lay the basis for further cooperation, which will be increasingly effective and efficient because it relies on cemented and reiterated cooperative practices. This study findings therefore highlight that when and how different actors are involved in the maternity care pathway of a woman is decided in an adaptive, case-specific fashion, based on the midwives’ experience, their consultation process with other midwives and network partners and in discussion and co-production with the women. Crucially, this work extends network governance theory by pinning down some of the micro-founded triggers of network activation, which are still not well-understood.

**Practical implications**

This study also goes to advance the current literature and practice around new, midwife-led models for maternity care to vulnerable women (Walsh & Devane, 2012). The project participants as well as the consulted archival documents underline the uniqueness of HAAMLA’s model, in the region and within the NHS at large. Although continuity of care and midwife-led models of maternity care are well-known and have gained increasing attention from policy and practice in the last two decades (Rayment-Jones et al., 2021; World Health Organization, 2016), HAAMLA is as an example of an early pioneer initiative that has become a well-established model, given its first conception in 1994, with four key aspects of distinction. First, whilst midwife-led, the model cannot be strictly classified under the continuity of care label, since the women’s intrapartum and childbirth period is handed over to the hospital team and carried out within hospital settings. Second, both the team workforce (midwives, support worker, interpreters) and services (antenatal care classes, home visitation, duration of antenatal and postnatal check-ups) are specialized on women with social risk factors and hence in vulnerable circumstances, unlike most models of midwife-led maternity in high-income settings that instead cater to all population segments (Sandall et al., 2024). Specifically in the UK, there are and have been initiatives and localized groups offering specialised care offer to women with social risk factors in community settings and along continuity of care principles, but they have often been short-lived because of funding and organisational restructuring (Rayment-Jones et al., 2021). Third, HAAMLA’s governance and practices are formulated from the ground up, thereby evolving in adaptation to the women’s needs, over time and across cases. Previous studies have highlighted the inherent holism of new midwifery models based on the continuity of care principle (Sandall et al., 2024), which recognize how pregnancy and childbirth constitute a transformative spiritual, social, psychological and physical event for a woman and her family. In this context, a need-based and trust-fostering approach is of paramount importance (Rayment-Jones et al., 2020; Simoncic et al., 2022). However, how these principles are operationalized for women with social risk factors, who themselves present stark differences given their complex, intersectional disadvantaged conditions have not been previously documented. Finally, HAAMLA’s services reach well beyond midwifery models to generate a support and bespoke advice network around the woman, with the help and contribution of several partner organisations and charities. While advocacy aspects within midwifery teams and professions have been documented (Fernandez Turienzo et al., 2021; Rayment-Jones et al., 2020), this is the first study that highlights the midwifery-led practices related to the governance of a complex network of partners in the public and voluntary sector.

Our findings corroborate earlier findings to illuminate the way in which alternative delivery and organizational models can make a significant different in access and uptake of maternity care (Fernandez Turienzo et al., 2021; Rayment-Jones et al., 2021; Sandall et al., 2024), and underscores the importance of inter-personal trust emerges as a key factor, in line with previous findings (de Kok et al., 2020; Rayment-Jones et al., 2020; Simoncic et al., 2022). Crucially, the HAAMLA also underlines the need for consultation, co-production, situatedness and adaptability of maternity care models, that should be tailored – where possible – to the perceived needs of the target group, through fluid and adaptive arrangements, with robust mechanisms to continuously monitor effectiveness and adapt accordingly. This suggests the importance of models and midwifery teams that are specialized on women with social risk factors, as opposed to midwife-led models that cater to the population of pregnant women without distinction. Importantly, these teams should be supported by adequate training provided to the midwives. In the words of the interviewed professionals, the current midwifery training proves insufficient and unsupportive to tailor care to vulnerable pregnant women and the system often fails to support healthcare professionals’ well-being and emotional resilience. The call is compelling for revising curricula or continuous professional development (CPD) pathways to include a much more rounded education offer, that is able to train specialized midwives who combine social work training with relational capabilities, enabling them to adequately interact with both women and external partners at the same time and in a co-evolutionary, synergistic fashion, much better aligned with the HAAMLA way.

**Limitations and directions for future research**

Even though nearly all specialized midwives working in the team have participated in the study, in addition to the team leadership (midwifery matron and team lead), because of the small size of the HAAMLA team, the evidence that could be collected through interviews is inherently limited. Future research could address this limitation by gathering additional evidence from comparable teams in other countries (since this case is unique in England) that are already active or will form in the near future. Another limitation relates to the absence of the pregnant women’s views. Although this was in line with the research design for this work, which specifically focused on healthcare professionals, gathering the perspectives of the women supported by HAAMLA would provide invaluable insights into their lived experience with the team and into the impact of the service.

From a theoretical point of view, this study is the first to consider how subjectivities at the intersection of social categories are perceived by and interact with, at higher-order levels of analysis, such as organisational and inter-organisational, and how this process translates in new, adaptive organizational arrangements of service delivery. However, other levels of the socio-ecological framework, such as communities, policies and the natural/built environment and related interdependences have not been included because of data limitations. Future research can address this limitation to more fully consider these aspects through multiple case study research, which more holistically looks at specific vulnerable groups along all the aspects highlighted in the proposed socio-ecological intersectional framework. Another interesting line of development will be the inclusion of interpreters and partner agencies in the data collection, to more fully understand and appreciate the HAAMLA from a network governance and partnership perspective.

**References**

Abma, T. A., & Stake, R. E. (2014). Science of the Particular: An Advocacy of Naturalistic Case Study in Health Research. *Qualitative Health Research*, *24*(8), 1150–1161. https://doi.org/10.1177/1049732314543196

Acker, J. (2006). Inequality Regimes: Gender, Class, and Race in Organizations. *Gender & Society*, *20*(4), 441–464. https://doi.org/10.1177/0891243206289499

Anderson, M., Pitchforth, E., Edwards, N., Alderwick, H., Mcguire, A., & Mossialos, E. (2022). Health Systems in Transition: United Kingdom. *Health Systems in Transition*, *24*(1). https://eurohealthobservatory.who.int/

Angeli, F., Camporesi, S., & Fabbro, G. D. (2021). The COVID-19 wicked problem in public health ethics: conflicting evidence, or incommensurable values? *Humanities and Social Sciences Communications*, *8*(1), 1–8. https://doi.org/10.1057/s41599-021-00839-1

Angeli, F., Jaiswal, A. K., & Shrivastava, S. (2022). Integrating poverty alleviation and environmental protection efforts: A socio-ecological perspective on menstrual health management. *Social Science & Medicine*, 115427.

Atewologun, D. (2018). Intersectionality Theory and Practice. In *Oxford Research Encyclopedia of Business and Management*. Oxford University Press. https://doi.org/10.1093/acrefore/9780190224851.013.48

Balaam, M.-C., Kingdon, C., Thomson, G., Finlayson, K., & Downe, S. (2016). ‘We make them feel special’: the experiences of voluntary sector workers supporting asylum seeking and refugee women during pregnancy and early motherhood. *Midwifery*, *34*, 133–140.

Bennett, S., & Scammell, J. (2014). Midwives caring for asylum-seeking women: research findings. *The Practising Midwife*, *17*(1), 9–12.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, *32*(7), 513–531. https://doi.org/10.1037/0003-066x.32.7.513

Brown, S. J., Sutherland, G. A., Gunn, J. M., & Yelland, J. S. (2014). Changing models of public antenatal care in Australia: Is current practice meeting the needs of vulnerable populations? *Midwifery*, *30*(3), 303–309. https://doi.org/10.1016/j.midw.2013.10.018

Costanza, R. (2014). A theory of socio-ecological system change. *Journal of Bioeconomics*, *16*(1), 39–44. https://doi.org/10.1007/s10818-013-9165-5

Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine. *University of Chicago Legal Forum*, 139–168.

Cristofoli, D., Markovic, J., & Meneguzzo, M. (2014). Governance, management and performance in public networks: How to be successful in shared-governance networks. *Journal of Management & Governance*, *18*, 77–93.

Dahlen, H. G., Drandic, D., Shah, N., & Cadee, F. (2022). Supporting midwifery is the answer to the wicked problems in maternity care. *The Lancet Global Health*, *10*(7), e951–e952.

de Kok, B. C., Uny, I., Immamura, M., Bell, J., Geddes, J., & Phoya, A. (2020). From global rights to local relationships: exploring disconnects in respectful maternity care in Malawi. *Qualitative Health Research*, *30*(3), 341–355.

Department of Health and Social Care. (2022). *Maternity Disparities Taskforce explores women’s health before and during pregnancy*. https://www.gov.uk/government/news/maternity-disparities-taskforce-explores-womens-health-before-and-during-pregnancy#:~:text=The%20Maternity%20Disparities%20Taskforce%20was,in%20the%20most%20deprived%20areas.

Donada, C., Nogatchewsky, G., & Pezet, A. (2016). Understanding the relational dynamic capability-building process. *Strategic Organization*, *14*(2), 93–117.

Dyer, J., & Kale, P. (2007). Relational capabilities: drivers and implications. *Dynamic Capabilities, Understanding Strategic Change in Organizations*, 65–79.

Esegbona-Adeigbe, S. (2020). COVID-19 and the risk to black, Asian and minority ethnic women during pregnancy. *British Journal of Midwifery*, *28*(10), 718–723. https://doi.org/10.12968/BJOM.2020.28.10.718/ASSET/IMAGES/MEDIUM/BJOM.2020.28.10.718\_F01.JPG

Evans, M., Plows, J., McCarthy, R., McConville, B., & Haith-Cooper, M. (2022). What refugee women want from maternity care: a qualitative study. *British Journal of Midwifery*, *30*(9), 502–511.

Fernandez Turienzo, C., Rayment-Jones, H., Roe, Y., Silverio, S. A., Coxon, K., Shennan, A. H., & Sandall, J. (2021). A realist review to explore how midwifery continuity of care may influence preterm birth in pregnant women. *Birth*, *48*(3), 375–388. https://doi.org/10.1111/birt.12547

Fiscella, K., & Shin, P. (2005). The Inverse Care Law: Implications for Healthcare of Vulnerable Populations. *The Journal of Ambulatory Care Management*, *28*(4). https://journals.lww.com/ambulatorycaremanagement/Fulltext/2005/10000/The\_Inverse\_Care\_Law\_\_Implications\_for\_Healthcare.5.aspx

Galle, A., Van Parys, A. S., Roelens, K., & Keygnaert, I. (2015). Expectations and satisfaction with antenatal care among pregnant women with a focus on vulnerable groups: A descriptive study in Ghent. *BMC Women’s Health*, *15*(1). https://doi.org/10.1186/s12905-015-0266-2

Gamberini, C., Angeli, F., Knight, L., Zaami, M., Al-Nasiry, S., & Ambrosino, E. (2023). Effect of COVID-19 on antenatal care: experiences of medical professionals in the Netherlands. *Reproductive Health*, *20*(1), 1–16.

Gioia, D. A., Corley, K. G., & Hamilton, A. L. (2013). Seeking Qualitative Rigor in Inductive Research: Notes on the Gioia Methodology. *Organizational Research Methods*, *16*(1), 15–31. https://doi.org/10.1177/1094428112452151

Goldsborough, N. (2020). *Leeds Maternity Health Needs Assessment*. https://observatory.leeds.gov.uk/wp-content/uploads/2020/08/Leeds-Maternity-Health-Needs-Assessment-April-2020-FINAL.pdf

Healy, G., Tatli, A., Ipek, G., Özturk, M., Seierstad, C., & Wright, T. (2019). In the steps of Joan Acker: A journey in researching inequality regimes and intersectional inequalities. *Gender, Work and Organization*, *26*(12), 1749–1762. https://doi.org/10.1111/gwao.12252

Higginbottom, G. M. A., Evans, C., Morgan, M., Bharj, K. K., Eldridge, J., & Hussain, B. (2019). Experience of and access to maternity care in the UK by immigrant women: a narrative synthesis systematic review. *BMJ Open*, *9*(12), e029478.

Holvino, E. (2010). Intersections: The simultaneity of race, gender and class in organization studies. *Gender, Work & Organization*, *17*(3), 248–277.

Kapilashrami, A., & Hankivsky, O. (2018). Intersectionality and why it matters to global health. *The Lancet*, *391*(10140), 2589–2591.

Khan, S. (2013). *Making Change Happen*. https://medicinehealth.leeds.ac.uk/download/downloads/id/240/making-change-happen---shaista-khan.pdf

King’s Fund. (2022). *Key facts and figures about the NHS*. https://www.kingsfund.org.uk/audio-video/key-facts-figures-nhs

Klijn, E.-H., & Koppenjan, J. (2016). *Governance Networks in the Public Sector*. Routledge, Taylor & Francis Group.

Klode, K., Ringer, A., & Hølge-Hazelton, B. (2020). Interprofessional and intersectoral collaboration in the care of vulnerable pregnant women: An interpretive study. *Journal of Interprofessional Care*, 1–10.

Koblinsky, M., Moyer, C. A., Calvert, C., Campbell, J., Campbell, O. M. R., Feigl, A. B., Graham, W. J., Hatt, L., Hodgins, S., Matthews, Z., McDougall, L., Moran, A. C., Nandakumar, A. K., & Langer, A. (2016). Quality maternity care for every woman, everywhere: a call to action. In *The Lancet* (Vol. 388, Issue 10057, pp. 2307–2320). Lancet Publishing Group. https://doi.org/10.1016/S0140-6736(16)31333-2

Koliba, C. J., Mills, R. M., & Zia, A. (2011). Accountability in Governance Networks: An Assessment of Public, Private, and Nonprofit Emergency Management Practices Following Hurricane Katrina. In *Public Administration Review* (Vol. 71, Issue 2, pp. 210–220). https://doi.org/10.1111/j.1540-6210.2011.02332.x

Laurenzi, C. A., Skeen, S., Coetzee, B. J., Gordon, S., Notholi, V., & Tomlinson, M. (2020). How do pregnant women and new mothers navigate and respond to challenges in accessing health care? Perspectives from rural South Africa. *Social Science and Medicine*, *258*, 113100. https://doi.org/10.1016/j.socscimed.2020.113100

Leeds Teaching Hospital NHS Trust. (2014). *What is Haamla*. https://studylib.net/doc/5483086/what-is-haamla%3F---leeds-teaching-hospitals-nhs-trust

Leeds Teaching Hospital NHS Trust. (2023). *Haamla Service*. https://www.leedsth.nhs.uk/services/maternity/team/haamla-service/

Lokot, M., & Avakyan, Y. (2020). Intersectionality as a lens to the COVID-19 pandemic: implications for sexual and reproductive health in development and humanitarian contexts. *Sexual and Reproductive Health Matters*, *28*(1). https://doi.org/10.1080/26410397.2020.1764748

Mandel, H., & Semyonov, M. (2016). Going Back in Time? Gender Differences in Trends and Sources of the Racial Pay Gap, 1970 to 2010. *American Sociological Review*, *81*(5), 1039–1068. https://doi.org/10.1177/0003122416662958

McCall, L. (2008). The complexity of intersectionality. *Intersectionality and Beyond: Law, Power and the Politics of Location*, *30*(3), 49–76. https://doi.org/10.4324/9780203890882

McKnight, P., Goodwin, L., & Kenyon, S. (2019). A systematic review of asylum-seeking women’s views and experiences of UK maternity care. *Midwifery*, *77*, 16–23. https://doi.org/10.1016/j.midw.2019.06.007

McLeish, J., & Redshaw, M. (2019). Maternity experiences of mothers with multiple disadvantages in England: a qualitative study. *Women and Birth*, *32*(2), 178–184.

Mcleroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An Ecological Perspective on Health Promotion Programs. *Health Education & Behavior*, *15*(4), 351–377. https://doi.org/10.1177/109019818801500401

Mohanty, C. T. (2013). Transnational feminist crossings: On neoliberalism and radical critique. *Signs: Journal of Women in Culture and Society*, *38*(4), 967–991.

Moore, L., De Silva-Sanigorski, A., & Moore, S. N. (2013). A socio-ecological perspective on behavioural interventions to influence food choice in schools: Alternative, complementary or synergistic? *Public Health Nutrition*, *16*(6), 1000–1005. https://doi.org/10.1017/S1368980012005605

Nowell, B., & Albrecht, K. (2023). A population ecology of network domains. *Public Management Review*. https://doi.org/10.1080/14719037.2023.2182903

Orcutt, M., Patel, P., Burns, R., Hiam, L., Aldridge, R., Devakumar, D., Kumar, B., Spiegel, P., & Abubakar, I. (2020). Global call to action for inclusion of migrants and refugees in the COVID-19 response. *The Lancet*, *395*(10235), 1482–1483. https://doi.org/10.1016/S0140-6736(20)30971-5

Phillimore, J. (2016). Migrant maternity in an era of superdiversity: New migrants’ access to, and experience of, antenatal care in the West Midlands, UK. *Social Science and Medicine*, *148*, 152–159. https://doi.org/10.1016/j.socscimed.2015.11.030

Pilato, T. C., Taki, F. A., & Kaur, G. (2021). Safeguarding pregnant asylum-seekers and refugees during the era of COVID-19. *Journal of Global Health*, *11*, 1–3. https://doi.org/10.7189/JOGH.11.03026

Provan, K. G., & Kenis, P. (2008). Modes of network governance: Structure, management, and effectiveness. *Journal of Public Administration Research and Theory*, *18*(2), 229–252. https://doi.org/10.1093/jopart/mum015

Provan, K. G., & Milward, H. B. (1995). A Preliminary Theory of Interorganizational Network Effectiveness: A Comparative Study of Four Community Mental Health Systems. *Administrative Science Quarterly*, *40*(1), 1. https://doi.org/10.2307/2393698

Raab, J. (2022). Organisational networks for sustainable development. In F. Angeli, A. Metz, & J. Raab (Eds.), *Organising for sustainable development: addressing the grand challenges*. Routledge: Taylor and Francis Group.

Rankl, F., Johnson, G. A., & Vindrola-Padros, C. (2021). Examining What We Know in Relation to How We Know It: A Team-Based Reflexivity Model for Rapid Qualitative Health Research. *Qualitative Health Research*, *31*(7), 1358–1370. https://doi.org/10.1177/1049732321998062

Rayment-Jones, H., Dalrymple, K., Harris, J., Harden, A., Parslow, E., Georgi, T., & Sandall, J. (2021). Project20: Does continuity of care and community-based antenatal care improve maternal and neonatal birth outcomes for women with social risk factors? A prospective, observational study. In *PLoS ONE* (Vol. 16, Issue 5 May). Public Library of Science. https://doi.org/10.1371/journal.pone.0250947

Rayment-Jones, H., Harris, J., Harden, A., Khan, Z., & Sandall, J. (2019). How do women with social risk factors experience United Kingdom maternity care? A realist synthesis. *Birth*, *46*(3), 461–474. https://doi.org/10.1111/birt.12446

Rayment-Jones, H., Silverio, S. A., Harris, J., Harden, A., & Sandall, J. (2020). Project 20: Midwives’ insight into continuity of care models for women with social risk factors: what works, for whom, in what circumstances, and how. *Midwifery*, *84*. https://doi.org/10.1016/j.midw.2020.102654

Riggs, E., Muyeen, S., Brown, S., Dawson, W., Petschel, P., Tardiff, W., Norman, F., Vanpraag, D., Szwarc, J., & Yelland, J. (2017). Cultural safety and belonging for refugee background women attending group pregnancy care: An Australian qualitative study. *Birth*, *44*(2), 145–152. https://doi.org/10.1111/BIRT.12272

Rodriguez, J. K., Holvino, E., Fletcher, J. K., & Nkomo, S. M. (2016). The theory and praxis of intersectionality in work and organisations: Where do we go from here? *Gender, Work and Organization*.

Romiti, A., Del Vecchio, M., & Sartor, G. (2020). Network governance forms in healthcare: empirical evidence from two Italian cancer networks. *BMC Health Services Research*, *20*(1). https://doi.org/10.1186/s12913-020-05867-2

Sandall, J., Fernandez Turienzo, C., Devane, D., Soltani, H., Gillespie, P., Gates, S., Jones, L. V., Shennan, A. H., & Rayment-Jones, H. (2024). Midwife continuity of care models versus other models of care for childbearing women. In *Cochrane Database of Systematic Reviews* (Vol. 2024, Issue 4). John Wiley and Sons Ltd. https://doi.org/10.1002/14651858.CD004667.pub6

Scheele, J., van der Vliet–Torij, H. W. H., Wingelaar-Loomans, E. M., & Goumans, M. (2020). Defining vulnerability in European pregnant women, a Delphi study. *Midwifery*, *86*, 102708.

Simoncic, V., Deguen, S., Enaux, C., Vandentorren, S., & Kihal-Talantikite, W. (2022). A Comprehensive Review on Social Inequalities and Pregnancy Outcome—Identification of Relevant Pathways and Mechanisms. In *International Journal of Environmental Research and Public Health* (Vol. 19, Issue 24). MDPI. https://doi.org/10.3390/ijerph192416592

Stake, R. E. (2000). *Handbook of qualitative research* (Denzin N. & Lincoln Y.  (pp. 435–454)., Eds.). Sage Publications Ltd.

Sword, W. (1999). A socio-ecological approach to understanding barriers to prenatal care for women of low income. *Journal of Advanced Nursing*, *29*(5), 1170–1177. https://doi.org/10.1046/j.1365-2648.1999.00986.x

Teece, D. J., Pisano, G., & Shuen, A. (1997). Dynamic capabilities and strategic management. *Strategic Management Journal*, *18*(7), 509–533.

van Blarikom, E., de Kok, B., & Bijma, H. H. (2022). “Who am I to say?” Dutch care providers’ evaluation of psychosocial vulnerability in pregnant women. *Social Science and Medicine*, *307*. https://doi.org/10.1016/j.socscimed.2022.115181

van Duijn, S., Bannink, D., & Ybema, S. (2022). Working Toward Network Governance: Local Actors’ Strategies for Navigating Tensions in Localized Health Care Governance. *Administration and Society*, *54*(4), 660–689. https://doi.org/10.1177/00953997211033818

Vedam, S., Zephyrin, L., Hardtman, P., Lusero, I., Olson, R., Hassan, S. S., van den Broek, N., Stoll, K., Niles, P., Goode, K., Nunally, L., Kandal, R., & Bair, J. W. (2022). Transdisciplinary Imagination: Addressing Equity and Mistreatment in Perinatal Care. In *Maternal and Child Health Journal* (Vol. 26, Issue 4, pp. 674–681). Springer. https://doi.org/10.1007/s10995-022-03419-0

Vestergaard, A., Langevang, T., Morsing, M., & Murphy, L. (2021). Partnerships for development. Assessing the impact potential of cross-sector partnerships. *World Development*, *143*, 105447. https://doi.org/https://doi.org/10.1016/j.worlddev.2021.105447

Walby, S., Armstrong, J., & Strid, S. (2012). Intersectionality: Multiple inequalities in social theory. In *Sociology* (Vol. 46, Issue 2, pp. 224–240). SAGE PublicationsSage UK: London, England. https://doi.org/10.1177/0038038511416164

Walsh, D., & Devane, D. (2012). A Metasynthesis of Midwife-Led Care. *Qualitative Health Research*, *22*(7), 897–910. https://doi.org/10.1177/1049732312440330

Ward, T., Clack, S., & Haig, B. D. (2016). The abductive theory of method: Scientific inquiry and clinical practice. *Behaviour Change*, *33*(4), 212–231. https://doi.org/10.1017/bec.2017.1

Warwick-Booth, L., Woodward, J., O’Dwyer, L., & Di Martino, S. (2018). *An Evaluation of Leeds CCG Gypsy and Traveller Health Improvement Project*. https://eprints.leedsbeckett.ac.uk/id/eprint/5410/

White, A., Erskine, S., & Seims, A. (2019). *The State of Women’s Health in Leeds*.

World Health Organization. (2016). *WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience: Summary*. Geneva, Switzerland: WHO Reproductive Health Library. Retrieved from https …. https://iris.who.int/bitstream/handle/10665/259947/WHO-RHR-18.02-eng.pdf

Zhong, Y., Zhao, H., Wang, X., Wang, M., Wang, L., & Ji, J. (2024). Voices of Parent-Carers Navigating the Care for Children With Osteogenesis Imperfecta. *Qualitative Health Research*, 10497323241272020. https://doi.org/10.1177/10497323241272020