



**Shared
Health
Foundation.**

Reducing the Impact
of Poverty on Health.

CRADLING MATERNAL DISPARITIES:

NO CRIB FOR A BED



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Shared Health Foundation 2026

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Introduction

Shared Health Foundation is a philanthropically funded CIC working to address health inequalities exacerbated by poverty.¹ In response to growing concerns about standards in temporary accommodation, the Foundation launched a Homeless Families project,² a service supporting homeless families and pregnant women placed in emergency and temporary accommodation in Oldham. From its inception, the service was based on the Focused Care model³ and was informed by midwifery frameworks and principles. Committed to reducing health inequalities, the service looked upstream to mitigate the negative impact of homelessness. Shared Health's trauma-informed, practice-based evidence, along with its specialist clinical insights, brought together a multi-disciplinary team, and we have shone a spotlight on the preventable health inequalities which can be affected by homelessness.

Rising concerns regarding the deepening housing crisis are being voiced by professionals and service providers across hospital waiting rooms, social and educational settings, and the weight of those who fall through the net is increasingly being met by charity and faith sector organisations.⁴ There is a deep sense of foreboding and urgent need to redress our existing systems, not by "throwing the baby out with the bath water" but by collating the wisdom from practice-based evidence and realigning the provision of services with the voice of the child at its heart.

This report aims to present the findings of Shared Health when examining the impact of local authority provision for homeless families through a maternal and reproductive health inequalities lens. Our service for families without a stable home identified a disproportionate number of women, many experiencing pregnancy alongside homelessness.

The work on the ground is led by a registered midwife with 25 years' experience working in areas of deprivation and consequently provides a unique midwifery-informed approach at our base called "The Crib". The service receives referrals from the local authority in one of Greater Manchester's most deprived boroughs, and we respond and offer support to those families with children, prioritising pregnant women and those with preschool children. Their lived experiences inform the service and how it responds to meet our guiding principle of health equity.⁵ We value co-production, and Shared Health wish to honour the incredible resilience of our families and their dedication to support our work and the compassion they show for others who are also in the journey themselves. With their consent, this report will ensure their stories are told, their voices are heard, and the whisper of the unborn is echoed.



Pregnancy and childbirth in every culture, tribe and tongue are revered as one of the most sacred rites of passage in a woman’s life and are often embedded in cultural traditions and community. It is an extremely social yet personal transition, as women evolve into motherhood and bring forth new life. A unique and treasured passage, for most it is veiled in mystery and able to spark the breadth of human emotion, from the elation and relief of a baby’s first cry to the deafening silence that marks hopes and dreams now lost . This transition should be protected as a time of preparation, safety and hope. However, for thousands of women across England, it coincides with the instability of homelessness and the harsh realities of living in temporary accommodation.

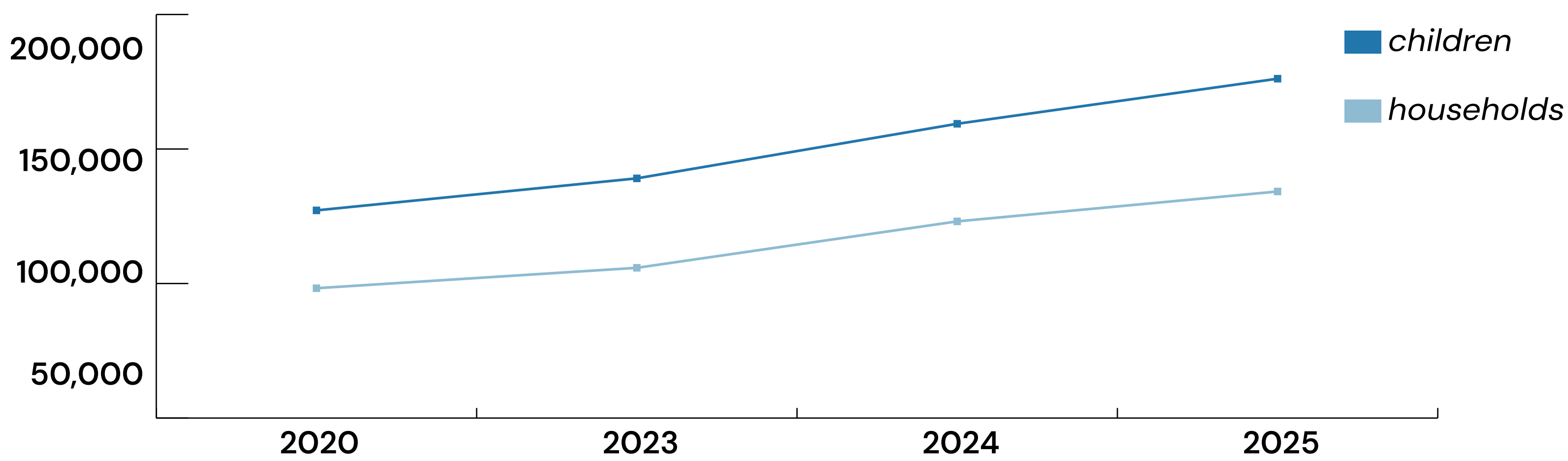
Our experience and insights seek to inform those aspiring to learn and offer best practice. Due to an existing culture of austerity, political instability and financial crisis at a local level, the impact of this national housing crisis is deepening. Sadly, the body of evidence is growing, and we can no longer ignore the reality that homelessness only compounds maternal and infant health inequalities.⁷

The National Picture of Homelessness Through a Reproductive Health Lens

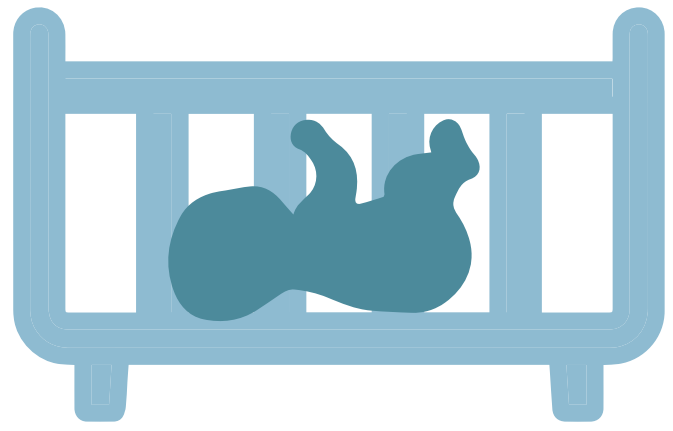
Homelessness in England has reached record levels. In 2025, over 134,210 households are living in temporary accommodation, including 176,130 children, 4,888 of which under 1 year old.⁸ Separate ad-hoc government publication estimates 20,000 babies under 1, without secure housing in 2023.⁹

Adding further to the complex landscape of homelessness is the variation in housing stock and the provision of emergency and temporary accommodation, as local authorities strive to meet their legal responsibilities from relief to main duty. Temporary accommodation takes many forms: hotels, B&Bs, hostels, houses of multiple occupation, and increasingly, modular units, shipping containers, and converted office blocks.¹⁰ Labelled as temporary, these spaces are often insecure, overcrowded, and wholly inadequate for family life. The scale of the housing crisis is not merely numerical, but we would suggest is a humanitarian disaster unravelling before our eyes in 21st-century Britain.¹¹

Figure 1: Number of households and children in temporary accommodation in England 2020–2025



20,000



babies under 1 year old
living in temporary
accommodation in 2023

460

pregnant women living in
temporary accommodation
in 2025¹²



The main drivers which force women into homelessness when pregnant are often multiple and complex. The list below is by no means exhaustive:

- Domestic violence
- Relationship breakdown
- Childcare responsibilities
- Long-term mental or physical illness
- Drug and alcohol dependency
- Debt
- Unemployment due to childcare responsibilities

Known as social risk factors, it is understood that multiple vulnerabilities can contribute to the precarious circumstances that lead women, disproportionately, into homelessness during this vulnerable perinatal period. Women raising children alone are unjustly affected, and due to their invisibility on our streets, they fall into a category some describe as England's "hidden homeless."¹³

Behind each homeless pregnant woman is a mother navigating pregnancy without the stability of a home and an unborn child whose earliest

environment is now marked by adversity. Once within the homeless system, the reality of its rigid parameters so often conflicts with what feels fair or even just. Families are left with unmet expectations with regard to priority status when pregnant. Frequent moves can feel like an endless journey, with the nine months of pregnancy just a fragment of time spent in temporary accommodation. The path into and through homelessness is complex and scattered with pitfalls.¹⁴

Shared Health continues to propose that homelessness is an adverse childhood experience clinically, practically, emotionally and socially. The negative impact homelessness has on this mother dyad relationship contributes to the earliest adverse childhood experience and does not mitigate potential safeguarding risks. The future of a generation is threatened due to a fragmented system and processes of homelessness, with insufficient access to secure homes for our most vulnerable mothers and infants. This denies dignity and the ability to prepare and provide the most basic of human needs, safe and secure shelter for their newborn babies.¹⁵



Redefining Homelessness and the Pregnant Homeless Woman

Homelessness is often misunderstood and frequently reduced in the general public's perception to a stereotype, often individuals (usually males) rough sleeping. The pregnant homeless woman is often depicted in literature and professional guidance as a minority group of rough sleeping, underweight, drug-dependent women, on the edges of the criminal justice system.¹⁶



The legal framework in England recognises a much broader spectrum. Under the Housing Act 1996,

“a person is homeless if they have no accommodation available, are at risk of violence, cannot reasonably occupy their current housing, or lack legal rights to remain. This means that women living in hostels, B&Bs, mobile homes without a permanent site, or overcrowded and unsafe housing are legally homeless even if they are not visibly on the streets”.¹⁷



However, definitions continue to evolve, trying to explain the complex experience of those living without a home. The European Typology of Homelessness and Housing Exclusion (ETHOS) expands this understanding further, identifying rooflessness, houselessness, insecure housing, and inadequate housing as overlapping forms of exclusion. These categories add further context to those who are “hidden homeless”. Thousands of front doors across the UK conceal the plight of homeless families who remain invisible in unreliable data sets, statistics and policy, simply because they are not seen sleeping rough on our streets.

The APPG for Households in Temporary Accommodation has, since 2020, consistently challenged the stereotypes around homelessness and the audience who perceive street homelessness as the main character when it comes to the story of homelessness. The “narrative around homelessness is changing”, families are becoming visible, and our commitment to effect policy has placed their predicament on a widening political stage.¹⁸

Our project has identified the hidden homeless plight of numerous pregnant women, caught within the homeless journey that labels them priority but rarely sees them. This invisibility is the reality for what is estimated around 20,000 women and is particularly dangerous as pregnancy and homelessness are both widely accepted in research as independent risk factors. Homelessness is neither static nor temporary, and for many, it can precede pregnancy, creating a catalyst where social and clinical vulnerabilities may result in poorer outcomes for both mother and baby. The nature of

pregnancy requires urgent action to mitigate these negative effects, but unfortunately, individual circumstances are often overlooked by systems and professionals working in silos, oblivious to this worrying trend where maternity and homelessness intersect.

Legal and Policy Framework

At first glance, the UK's legal framework appears to offer strong protections for pregnant women experiencing homelessness. The Housing Act 1996 and subsequent legislation, including the Homelessness Reduction Act 2017, identify pregnancy as a priority need. Local authorities are required to provide relief duty for 56 days and to prevent or minimise homelessness wherever possible. However, the lived experience of many pregnant women is that protection and security are not a priority for the local authority holding their housing duty. Their experience of pregnancy is overshadowed by the issue of survival throughout the homeless journey.

Housing Act 1996: Pregnant women and their families are recognised as priority need, but the quality and suitability of temporary accommodation is not guaranteed.

Homelessness Reduction Act 2017: Extends duty to refer, requiring public bodies — including maternity services — to act early.¹⁹ However, inconsistent implementation and fear of stigma mean many women do not disclose their pregnancy, therefore they remain unsupported. Furthermore, midwives feel ill-equipped to enquire routinely regarding the issues surrounding unstable housing and feel the weight of moral responsibility when practical needs present.²⁰

Children's Act 1989: Places responsibility on local authorities to safeguard children in need. In practice, this often translates into reactive rather than preventative interventions.

Human Rights Act 1998: Enshrines the right to family life and adequate housing, yet enforcement is weak when families are placed in unsafe or unsuitable accommodation.

The gap between policy and practice is stark. Families are frequently moved with little notice, even during labour or immediately after birth. Out-of-area placements disrupt access to primary care, and maternity care is fragmented. Despite statutory duties to safeguard health and ensure even the most basic of human needs, for example, the ability to access stable, nutritious food, this is universally missing for all families at certain stages of the homeless journey. The system appears chained to bureaucracy to prioritise numbers and housing stock over safety, leaving pregnant women in an automated system, void of compassion and exposed to instability, trauma, and risk. If we compare this to the legislative protection for badgers, then the legislation to protect our most vulnerable mothers is in urgent need of reform.²¹





Figure 2: Baby or Badger – comparison between policies protecting badgers and homeless families in temporary accommodation.

Pregnancy in TA

Pregnancy magnifies the vulnerabilities of homelessness. When women are placed in emergency accommodation, they face not even basic amenities, unsafe environments, safeguarding concerns regarding mixed accommodation, frequent moves, and a lack of privacy.

May I take this opportunity to introduce Bethan, expecting her first baby in February 2026. She has just started her maternity leave and is currently in her first temporary accommodation following her time in a hotel.

"Being in temporary accommodation on your own, pregnant, is not easy. Most of the time, you're not allowed visitors, so trying to do everything on your own is extremely difficult. From taking your shopping bags in on your own, up flights of stairs, because no one is allowed in to help you, can

can stress you out and strain you.

I am currently in a small box room with a single bed, 4 cupboards, a small fridge (not a fridge freezer, just a fridge), a kettle and a microwave. The facilities are very limited; they do have a bigger communal kitchen, but I don't use this because I'm on my own. I don't like going all the way down the hallway with my food and cutlery; I feel unsafe, especially at night. There's also a communal washing machine, but they charge you £1 for each wash. This isn't right for struggling people, including myself. The rooms can make you feel

CLAUSTROPHOBIC AND LONELY.

When I moved into this temporary accommodation, the room was dirty and dusty, and the bed was broken, and the lock on the door didn't work properly. This is all fixed now after complaints and contacting multiple people, including the accommodation and the homelessness officer.

There are security guards that check on you, but some of them come late at night, and

I DIDN'T FEEL SAFE

answering the door to them. They also said they can let themselves in your room if you don't answer the door, for a welfare check. So far, they haven't let themselves in, but with them saying this, it makes you feel powerless and vulnerable, knowing you can't do anything about it.

There is a single window overlooking the back street, and the room is too small to put anything of your own furniture up or even store enough food. I go out every two days for groceries, it's not ideal at all, especially knowing you must store baby furniture and set up for the arrival.

IT'S NOT IDEAL OR SAFE FOR KIDS OR NEWBORNS HERE;

we should be top priority, able to live in safety. For families and mums to be, it just puts stress and anxiety on us, not good for wellbeing. Knowing there is nothing we can do about it but wait for a better opportunity.

Going on to maternity leave is difficult because your money can get cut in less than half. A time when you need your money the most, struggling to get by and buy the baby's essentials is hard enough without worrying about yourself. It leaves you stressed out all the time about

NOT HAVING

ENOUGH TO GET BY

and budgeting all the time.

I find myself in constant worry and feel out of control in case there is an emergency, and I can't get the things I need.

IT MAKES YOU LESS EXCITED ABOUT THE FUTURE,

because it's out of your control. Most of the time, even though there is help, you feel ashamed. Having to ask for it or go without, I know this is the case because

I FEEL ASHAMED

ASKING FOR HELP,

because I know there are people that are far worse off."

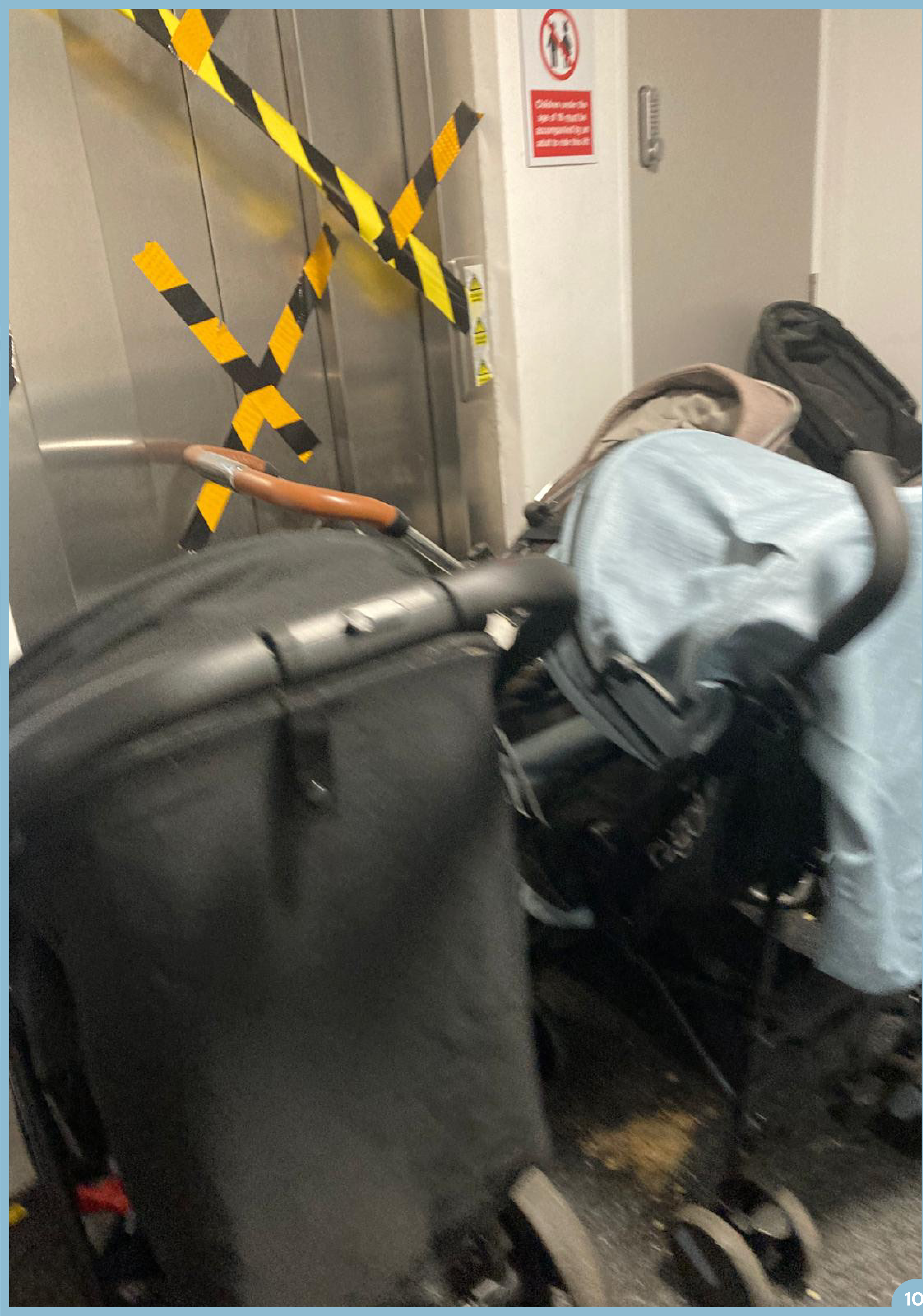
—Bethan, 2025

It is well-documented that health inequalities associated with deprivation are compounded by systemic bias, institutional racism and workforce strain. These intersecting vulnerabilities negatively impact maternal, infant and family health outcomes and are often pervasive across their life course.²²

Sadly, the journey through homelessness is rarely short; the months of pregnancy are often only a fragment of the time families spend in temporary accommodation. For many, this continues into the early years of their child's life, with profound consequences for maternal and infant health. Due to ongoing austerity and pressure on all front-line services, workforce and financial restraints lead to a compromised offer for pregnant women. Neither enough housing stock to ensure just one suitable accommodation for all pregnant women (until a tenancy is secured) nor enough specialist midwives trained and aware of the clinical implications for the perinatal period whilst women are insecurely housed.







Due to the scarcity of research available, it is impossible to ensure what is best practice for homeless pregnant women living in temporary accommodation in the UK. It is imperative that guidance from MBRRACE-UK and NIHR is followed to secure more funding for research,²³ to ensure the experiences and outcomes of this vulnerable population group are more fully understood. Shared Health has collaborated with researchers from different disciplines,²⁴ including Cummings 2025.²⁵ This project is one of the first to not only research the lived experience of homeless pregnant women living in temporary accommodation but also the experience of third sector professionals supporting them. Cummings et al. (2025) have created an infographic to facilitate midwives' daily practice and support professional development for practising midwives and the students they teach.

Semi-structured interviews conducted with mothers reveal recurring themes:

Unsafe spaces: rooms unsuitable for recovery after birth, lacking basic facilities such as kitchens or safe sleeping arrangements for infants.

Frequent relocations: families moved with little notice, sometimes during labour or immediately after delivery.

Erosion of confidence: mothers report feeling unseen by maternity services, undermined in their ability to parent, and invisible within bureaucratic systems.

Mental and emotional toll: the instability of housing compounds trauma, shame, and anxiety, leaving women isolated at a time when support is most needed.

A Changing Role – Midwives, Homelessness and Continuity of Care

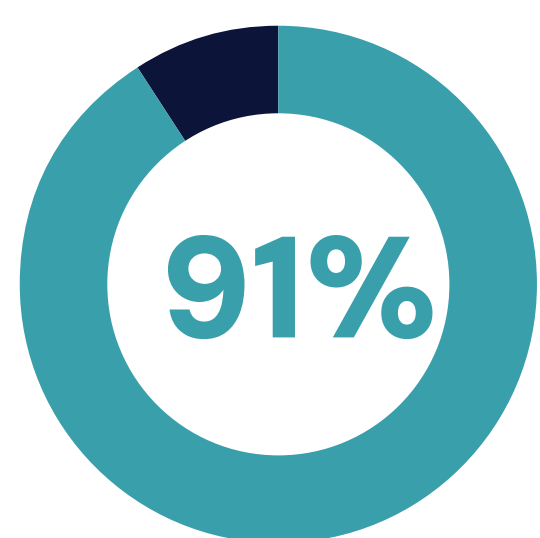
Throughout Ancient civilisations, midwives have been privileged and uniquely positioned to identify and respond to women at this most vulnerable time. Wise women responding to a call to be “with woman” would intuitively observe and identify risk, frequently intervening to prevent disaster. Present times are no different; the RCM guidance regarding the role of the midwife ensures newly registered midwives understand their role, and central to it is the skill to recognise potential harm.²⁶

A Survey by the RCM 2021 showed that nearly all midwives in the UK have cared for pregnant women experiencing homelessness, but unfortunately, systemic gaps in legal frameworks, organisational structure, operational policies and hierarchy can limit their autonomy to respond.²⁷

Midwives hold a routine line of enquiry from booking to discharge, identifying potential risk, abuse and ensuring wellbeing. However, rarely resourced to complete home bookings, midwives do not routinely see the environment women are living in until the postnatal period. Surprisingly, current practice in the UK does not routinely ask regarding housing status, and it is not a national mandatory question to be documented within maternity notes. When workforce restrictions and staffing remain minimal, women may not be seen by a known midwife, and this routine line of enquiry can then be disrupted. This is known to impact relational trust, which is vitally important between a midwife and a mother. It is essential to enable women to feel safe to disclose and share the

hardships they face regarding housing. Without trust, fear of social services and perceived implications can make it extremely difficult and accentuate feelings of shame. Women report feeling judged and sometimes feel prevented from disclosing their full circumstances.²⁸ Experienced midwives are skilled at listening intuitively and exercising professional curiosity, but few have been trained regarding the social determinants of health in relation to the complexity of homelessness. The role requires the willingness to ask difficult, necessary questions, but this can be limited when midwives do not feel confidently trained and the resource of time is poor or not protected.

The State of the Nation report by MBRRACE-UK, "Saving Lives, Improving Mothers' Care" (2025), highlights further the constellation of bias when reviewing the care of 643 women of the 583 who died; 91% faced multiple interrelated challenges.²⁹



583 WOMEN

out of the 643 who died, faced multiple interrelated challenges.



Key messages

from the confidential enquiries 2025



A constellation of biases

The 2025 MBRRACE-UK report looks at the care of **643 women** who died during or up to one year after pregnancy in the UK and Ireland

Of these women, **583 (91%)** faced multiple interrelated challenges

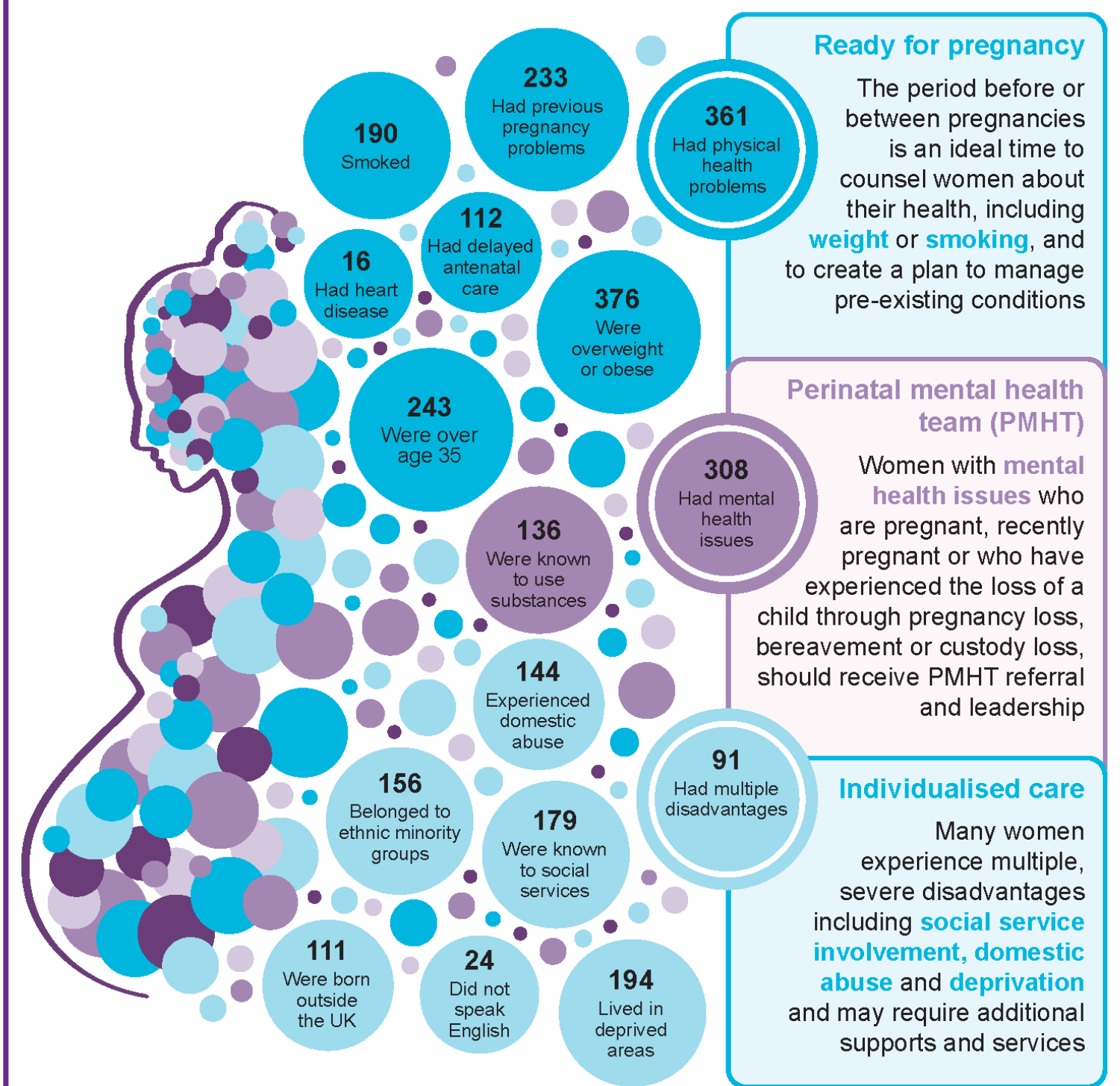


Figure 3: A constellation of biases

MBRRACE-UK continues to evidence the consequences of multiple complexities and the urgent need to ensure susceptible groups receive not just tailored care but timely care. Chief Midwifery Officer Jacqueline Dunkley-Bent ensured her term at the RCM was committed to leading and facilitating the reduction of health inequalities with ambitions to roll out continuity of care for those women and families who most need it.³⁰ She also championed a "progressive universal approach" rather than one where women and families pass between universal, targeted and specialist support. Progressive universalism secures continuity of relationships, ensuring specialist services support access and engagement with universal professionals, rather than requiring

families to “step in and out” of services. Homeless pregnant women and their families could be one such group who could benefit from receiving a continuity of care service, embedding support into an ongoing, longer-term relationship.³¹

This further aligns with the “two triangle” model,³² the Maternity Transformation Programme,³³ and the 10 Year Health Plan for England,³⁴ which suggests one model could be specialist continuity of care, ensuring the most vulnerable are reached, moving from ‘hospital to community’, ‘sickness to prevention’. The weight of evidence builds a sobering picture: “We have seen significant pressures in maternity services in the recruitment and retention of midwives and obstetricians. Workforce planning, reducing attrition of maternity staff, and providing the required funding for a sustainable and safe maternity workforce is essential.”³⁵

The reality remains that women with multiple disadvantages, living in the most deprived areas, are more likely to experience pre-term birth, stillbirth,

neonatal death and maternal mortality. The MBRRACE-UK and Health Plan commitment to continuity pathways is targeted “towards women from BAME communities and those living in deprived areas for who midwifery led continuity of care is linked to significant improvements in clinical outcomes”. This should specifically include homeless pregnant women who need social vulnerabilities and physical symptoms to be reviewed simultaneously. Unfortunately, without structural support, midwives cannot bridge the gap alone, but continuity of care could ensure longer appointments and trauma-informed practice for pregnant homeless women, so their wider social vulnerabilities are considered. Shared Health’s unique and specialist Homeless Families service supports universal professionals access whilst ensuring continuity and engagement with the correct care pathways, in a timely manner, throughout the perinatal period. This is further recommended in the new guidance for practice to ensure effective care continuity between midwifery and health visiting services.³⁶

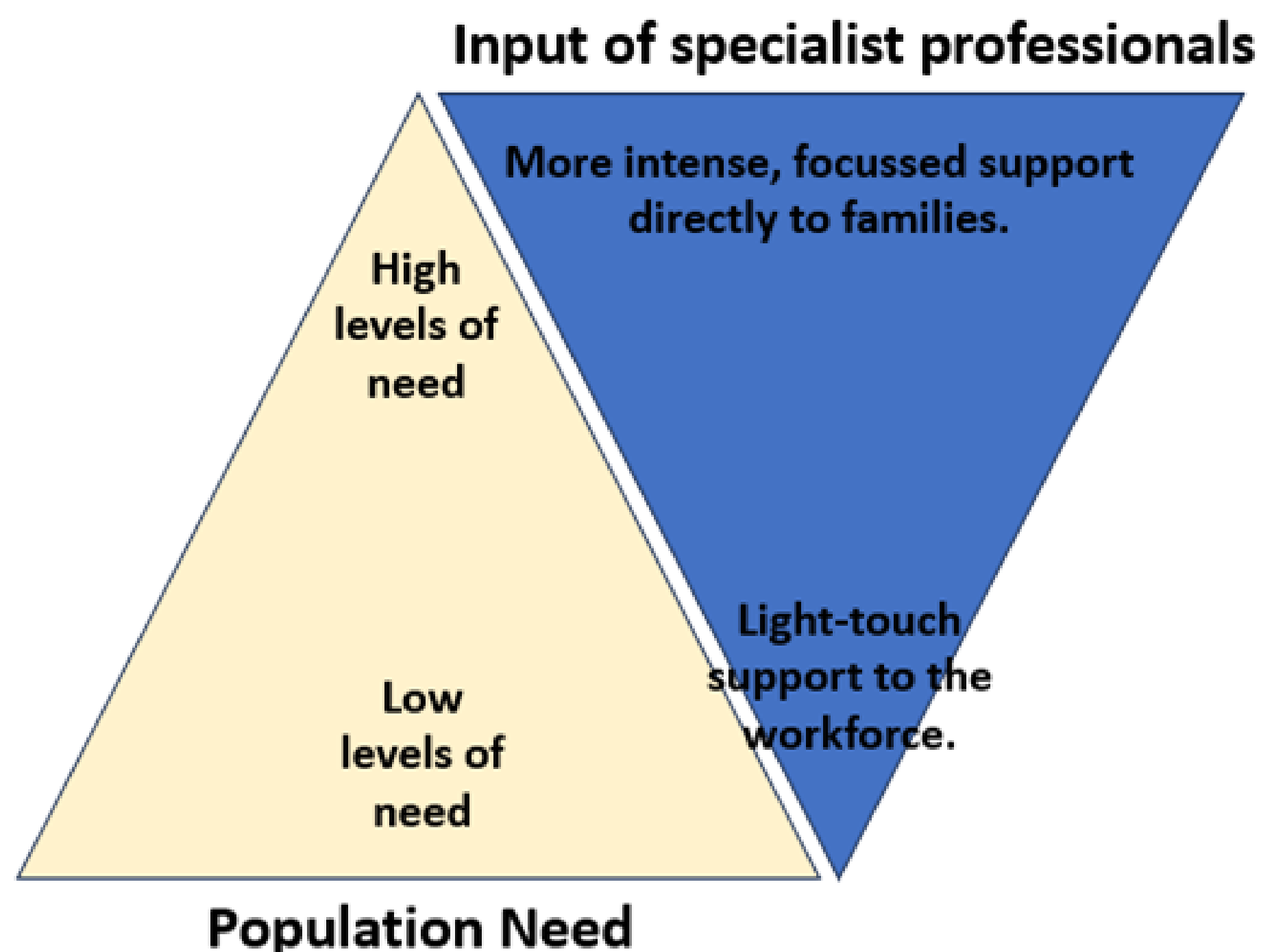


Figure 4: The “two triangle” model

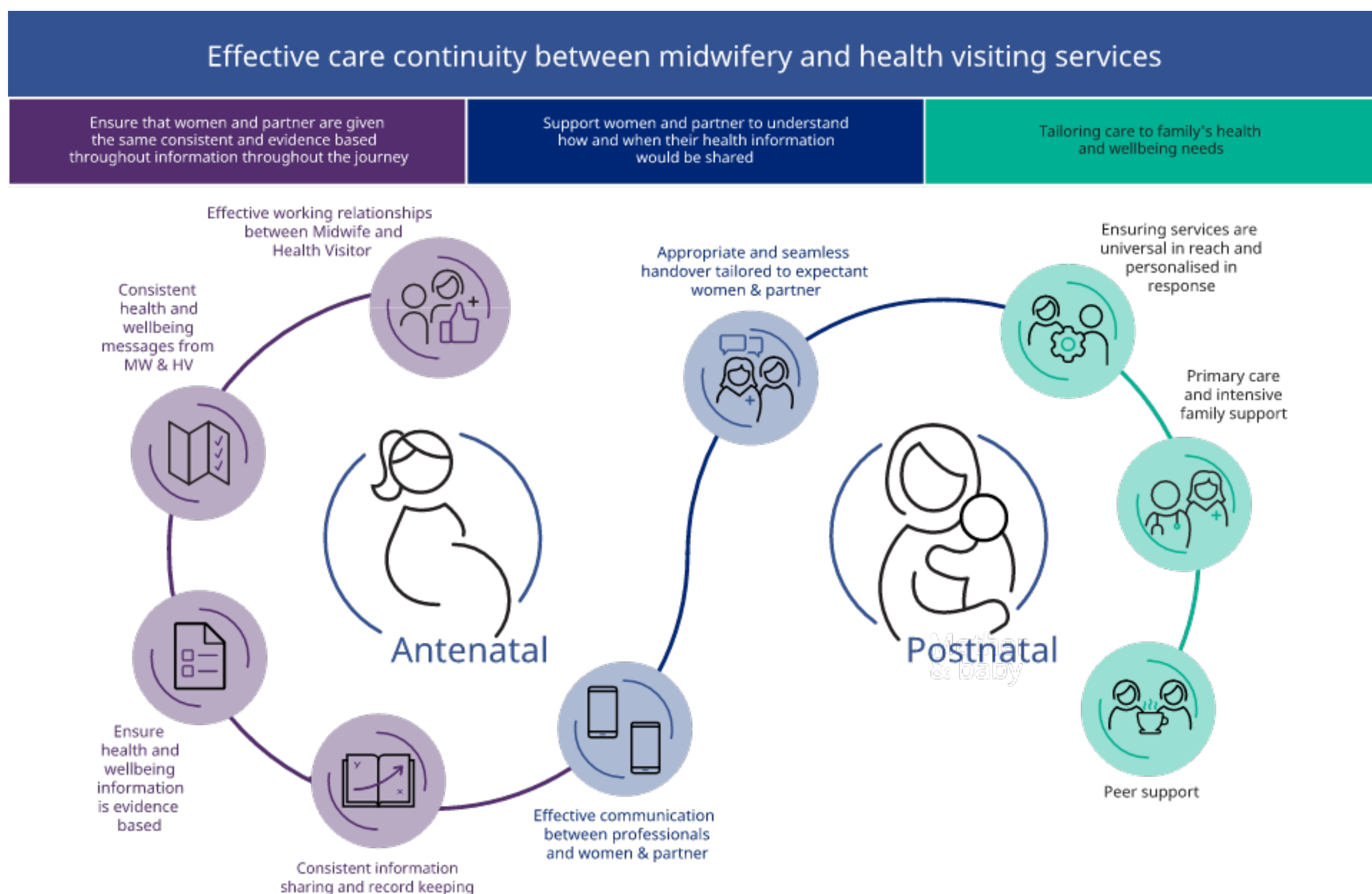


Figure 5: Effective care continuity between midwifery and health visiting services

Shared Health approached accessing this vulnerable population by engaging at the point of homeless duty, being accepted by a local authority. This referral point engages those pregnant within the homeless system at its earliest stage in the journey. Clinical expertise in pregnancy and early years keeps the mother-baby dyad at the centre of interventions, looking upstream to inform care plans and tailored support. A systematic review by Khan et al. (2023) appears to support this approach, summarising that multi-interventional approaches could enhance a targeted approach for at-risk populations.³⁷ Combining models of care with community-centred approaches enhances accessibility, earlier engagement and increased attendance. This was shown to include women who experience multiple and severe social disadvantages, including but not limited to homelessness, poverty, domestic abuse and those from minority ethnic groups. Further research is needed to understand the impact of such services.³⁸

Investing in the emotional wellbeing of our babies is a wonderful way to invest in the future.

Giving children the best start in life.

Improving the mental and physical health of the next generation.

Reducing risky and antisocial behaviour and the costs they bring.

Building a skilled workforce to support a thriving economy.

Creating a compassionate society.



The **first 1001 days**, from conception to age two, is a period of rapid growth. During this time **babies' growing brains** are **shaped by their experiences**, particularly the **interactions** they have with their parents and other caregivers. What happens during this time lays the **foundations for future development**.



Early relationships between babies and their parents are incredibly important for building healthy brains.

I need a **secure relationship** with at least one sensitive, nurturing caregiver who can respond to my needs.



Supporting my parents and other important people in my life to develop this relationship will give me the best start in life.

Stress factors such as domestic abuse and relationship conflict, mental illness, substance misuse, unresolved trauma and poverty can make it harder for my parents to provide me with the care I need. The more adversities that my family experiences, the harder it can be to meet my needs.



Healthy social and emotional development during the first 1001 days:

- Lays the foundations for lifelong mental and physical health.
- Means I feel safe and secure, ready to play, explore and learn.
- Leaves me ready to enjoy and achieve at school, and progress in the workforce.
- Enables me to understand and manage my emotions and behaviours; which means that I can make a positive contribution to my community.
- Gives me skills to form trusting relationships and to be a nurturing parent myself; sowing the seeds for the next generation.



Tackling adversity + supporting early relationships healthier brains + better futures

References and further information can be found on <https://1001days.org.uk/resources>



Figure 6: Investing in the emotional wellbeing of babies

Nutrition and Food Insecurity: A Common Theme

Nutrition is the cornerstone of maternal and infant health, yet for homeless families, it is one of the most fragile foundations. Emergency and temporary accommodation are often located in food deserts, defined as “an urban area in which it is difficult to buy affordable or good quality fresh food” in the Oxford English Dictionary. As a relatively new term, many clinical staff are unaware of its definition or implications for pregnant women.

The practical impact of not having utilities available, the lack of basic kitchens, appliances, utensils, refrigeration or storage, forces women to rely on food purchased immediately before consumption.³⁹

The result is a diet dominated by ultra-processed foods and takeaways — high in calories but low in nutrients, and forcing them into further financial hardship.

Despite the lack of research specific to temporary accommodation and pregnancy, wider research highlights the risks of ultra-processed food and high consumption:

Maternal health: diets heavy in ultra-processed foods are linked to obesity, malnutrition, anaemia, low B12, folate, depression, and chronic disease.⁴⁰

Pregnancy outcomes: studies suggest associations between poor maternal diet and neonatal hypoglycaemia, gestational diabetes, low birth weight and increased infant morbidity.

Infant feeding: breastfeeding offers protection, reducing reliance on processed foods in early childhood. Mothers who are displaced can often lack access to basic nutritional food and the essential support to initiate or sustain breastfeeding.

The first 1,001 days of life are critical for development.⁴¹ Malnutrition during this period can shape lifelong health, influencing risks of obesity, cardiovascular disease, and poor educational attainment. Specifically for homeless mothers, food insecurity compounds the daily reality and trauma of housing instability, leaving them destabilised and undermined in their ability to prepare for birth at even the most basic human need for nutritious food.

Irrespective of the well-documented harms of ultra-processed foods, research specifically focused on pregnant homeless women remains scarce.⁴² This gap in evidence mirrors the invisibility of their experiences in policy and practice and minimises local authorities' responsibility to house with suitable access to nutritious, affordable food. Addressing nutrition in temporary accommodation is not a matter of choice but an urgent necessity — a minimum standard that must be met to safeguard maternal and infant health, which is well overdue. Many local authorities do not add the breakfast component to the booking, further limiting access to even the most basic meal of the day.





Recent government announcements regarding the increased allowance for Healthy Start commenced in April 2026, which would allow more healthy foods and milk to be subsidised.⁴³ Further discussions regarding eligibility and access to the card continue, attempting to improve access for those trying to apply. Included in this scheme is the ability to access Healthy Start vitamins for women, but repeatedly, women report difficulty accessing distribution centres, even if in receipt of the vouchers.

Preconception & Accessing Maternity Services for Antenatal Care

The support of consistent clinical messages to “get ready for pregnancy” are presented by MBRRACE-UK as a missing but essential component to reduce health inequalities and improve public health programmes throughout the life course. However, access to reproductive interconception care⁴⁴ and preconception care is often limited and varies depending on postcode, digital access and first language.⁴⁵ Furthermore, homelessness is indiscriminate and touches the lives of those who find themselves pregnant and those desperate to conceive or start a family after a baby loss. The experience of baby loss can magnify the desire to gain information and access support giving reassurance and guidance to establish healthier lifestyle choices, restoring hope for a future pregnancy.



Additional support that our service has found to be beneficial for families in this period is:

Support to access good counsel regarding physical, emotional and mental health support.

Behavioural activation in areas such as smoking cessation, weight management, sexual health and family planning, as well as engagement with assisted recovery services.

Supporting women between pregnancies to address the modifiable interventions which may help to reduce risk factors and help improve overall outcomes in maternal and infant health.

Supporting health literacy regarding individual risks, to support self-advocacy and confidence to discuss and seek early specialist review when pregnancy is confirmed.

Due to this lack of accessible health literacy, even the most basic preconception advice is often not taken, resulting in inadequate folic acid and vitamin D prior to pregnancy, whether planned or unplanned.

Access to primary care and maternity services can be hindered by needing digital access and having IT literacy at a level high enough to be able to navigate sometimes complex registration or processes to access referral services. This may be complicated by women's level of literacy or if English is not their first language. This is only made more complicated when navigating the health system in pregnancy. Themes around poor communication continue to surface between professionals working in silos and communication with women whose first language is not English. The

lack of translation services can add another harmful effect on both maternal and infant outcomes.⁴⁶

Particularly problematic is when pregnant women are moved frequently between temporary accommodations, as GPs work within geographical areas. This can lead to delays in access to universal services, maternity, and time-specific screening programmes.

"I eventually was given midwife appointments and scans, which became a struggle. My hospital was in Oldham, so early appointments were especially hard, rushing around to

TRAVEL 2 HOURS TO MAKE IT ON TIME.

I felt drained physically and emotionally, my hormones were constantly fluctuating, I felt like I was losing everything and

HAD NOTHING TO OFFER MY NEW BABY.

I spent a lot of time in the bedroom as I wasn't familiar with the area and didn't know anybody. I spent many nights in the bathroom crying,

FEELING HOPELESS WITH NO ONE TO TURN TO FOR HELP AND SUPPORT."

–Isabel, 2025

The NICE Guidance on Antenatal care specifies what is deemed as a minimal level of care as being booked at less than 13 weeks of pregnancy and 3 or fewer antenatal appointments, whereas optimal care is before 10 weeks of pregnancy and no missed appointments.⁴⁷ Transition to digital notes and confirmation of pregnancy no

longer held in primary care results in the ability to access self-referral information online and creates numerous barriers for timely referral to avoid late booking.⁴⁸

Complex Pregnancy, Domestic Violence and Safeguarding

Due to the nature of welfare provision, our service has seen many women fleeing domestic violence whilst pregnant, with complex and multiple vulnerabilities. In line with legislation, the local authority has a legal duty firstly to accept out-of-borough women and give them main duty, and secondly, due to threat to life, escalation and breach of non-molestation orders, women are advised to present anywhere they feel they may be safe.⁴⁹

Please let me introduce you to Lisa. She has now had to move four times with her 10-year-old son and is 28 weeks pregnant with her second son. Since childhood, her story is scarred with abuse, neglect and trauma, and has resulted in complex mental health, lifestyle choices, and mistrust in services.

"I've been on the social services throughout this full pregnancy, through the fact of domestic violence, and that I'm homeless; it's frightening having them involved, but I need support. The Crib place is what women need.

I've got a fearful pregnancy. I've got a complex pregnancy, very large complications now, the blood flow is not very good. So, I'm at the hospital twice a week, The Crib offers me loads of support, somewhere to go if I need a shoulder to cry on. I've been through a lot of bad stuff. Domestic violence, I've been beaten with a hammer and stuff.

The guy who did it, he's got ten and a half years in jail for it. I've smoked since I were a nine-year-old, a 50g every three days,

I WOULD NEVER, EVER

HAVE STOPPED SMOKING,

IF IT WEREN'T FOR ANGIE,

actually sitting down and talking to me, and now I've got patches and not had a fag for two weeks. She also convinced me, well, I won't say convinced me, I spoke to her, she broke it down to me and then going back to the doctors for my mental health med review, which I stopped taking my tablet off me own. Off me own, which I shouldn't have done because it's for my mental health. But she did. I got an appointment booked and she came with me; she stood by me.

THE CRIB, WOMEN NEED IT.

100%, WE NEED IT,

without I don't know what I have done so far, to be honest. "

- Lisa, 2026

Intrapartum

For those who find themselves still homeless and approaching delivery, the stress and strain to prepare and "nest" is palpable and filled with frustration. As gestation progresses and calorific demand increases, difficulty in movement and urges to nest align with a strong motivation to seek social support. Furthermore, the drive to store food, easy to prepare, becomes an essential need for women as they prepare for birth and is frequently reported as a stressor when unable to complete.⁵⁰ Limited space with increased financial hardship, due to the additional costs of living in temporary accommodation, means

limited resources for essential equipment for baby's arrival. The anxiety of a text or call saying they must move detracts attention further and leaves little room for feeling excited or or emotionally ready. Chaos often results in the coordination of moving belongings and getting ready to bring a baby "home."



Most women in the UK go spontaneously into labour, which is normal and natural, but there is no specific way to determine when labour will commence. This “not knowing” creates heightened anxiety and uncertainty when restricted in insecure, inappropriate accommodation, which sometimes can be out-of-borough and located in unfamiliar surroundings.

Women with a low-risk pregnancy with no involvement from social care could experience minimal level support from maternity services and never disclose they are insecurely housed. Anecdotal evidence from women and midwives reveals that, due to shame and fear of referral to social services, this disclosure can be made prior to postnatal discharge. If they have been local to the area with prior connection to universal services, in receipt of benefits, or are working with a strong social network, their housing status may never be asked, recorded, or recognised as a potential social risk factor. Delivery can be a time when this first becomes known, especially if suddenly asked to move accommodation.

When early labour commences, it can be an anxious time, needing safe and comfortable surroundings which encourage optimal normal progress. However, due to the work of Shared Health, standards in temporary accommodation have been revealed. Work continues to identify and call local authorities to remedy unsatisfactory accommodation where mould, infestations, vermin, damp, cold and dirty realities make for uncomfortable surroundings. Initial labour advice would routinely advise the company of close carers, warmth, access to a bath and food to nourish the demands of early labour, a far cry from most temporary accommodation.

The decision to choose where to have a baby should be a process of informed choice, with guidance from a midwife. The reality for women in the homeless journey is juxtaposition to those in secure accommodation. In the duration of our work at Shared Health, it is noted that no woman has requested a homebirth, and it has not been brought to our attention regarding any BBA deliveries (baby born before arrival). This could suggest that early presentation in labour is potentially a labouring homeless woman’s survival plan, suggesting potentially another area for further research.

Practical Barriers to Access & Engagement with Services

Digital access and available data are also frequently reported and associated with concern regarding labour, for example, needing to call ambulances or taxis. Depending on location and coverage in the temporary accommodation, this poses a risk known as a digital desert, which “refers to geographical area where residents have limited or no access to reliable, affordable internet connectivity and devices sufficient to support access”.

Women requiring specialist pathways recognise a more robust layer of professional care whilst they remain located within the hospital catchment area and can attend. However, the need for financial resources to attend additional appointments via public transport is frequently identified as another barrier. Most women are not routinely offered support to access NHS travel cost reimbursement if they are financially or socially vulnerable and in temporary accommodation.

Women under specialist care who experience emergency admissions or treatment may require wider consideration if they have other children. Unfortunately, when emergency treatment is required, this can lead women to consider the least risky solution. Some of the women we have met have felt forced to quickly rely on newly forged friendships. Frequently, these are other mums in the same accommodation or those they have just met within the community who become emergency support networks.

“WE WERE MOVED TO A THIRD TEMPORARY ACCOMMODATION, AND BABY ARRIVED EARLIER THAN EXPECTED.

I went to hospital again, feeling dizzy, worn out, not feeling much movement. 10 minutes after being in hospital, it was declared that his heartbeat had stopped, leading us to a very rushed emergency C-section.”

– Lilly, 2025

Safeguarding and welfare checks should be considered in these instances, and can often leave women torn and with limited options. For some, they are left no choice but to reluctantly engage in estranged relationships simply due to the restraints of the temporary accommodation, hospital policies and a lack of social care. This is only made worse when inpatient stay is extended, for example, when babies need support in NICU, and no rooming-in options are available.

Hospital Discharge and Postnatal

The period following birth should be one of rest, recovery, bonding, and support. The reality for many of the mothers we meet means hospital discharge marks the beginning of a profoundly isolating experience, returning to emergency or temporary accommodation designed for a night or two. For those who have not secured a tenancy, this becomes the setting for weeks of isolated postnatal recovery. Whilst for professionals striving to ensure safe hospital discharge, a myriad of both practical and safeguarding barriers arise to ensure this is achieved.⁵¹

The standards and conditions in temporary accommodation:

Restrictions on visitors, meaning fathers, grandmothers, sisters, or friends, are often excluded unless formally listed on housing applications.

Displacement due to domestic violence, with women placed out of borough for safety or kept at a “safe distance” from perpetrators, further severing support networks.

No access to kitchens or fresh food, leaving mothers reliant on ultra-processed meals or takeaways.⁵²



The negative consequences are both practical and emotional for women recovering from childbirth, which can involve major surgery. Adapting to motherhood without a home takes a heavy toll. Families report being moved with little notice, even a week before delivery or on the day of a caesarean section. Through the work of Shared Health, the Systemic failures which compound these challenges have been witnessed and documented in real time by our incredible families. They understand that without their voice, the stories will continue simply through another family's experience.

Please let me introduce Sara, a mother whom we met at 32 weeks of pregnancy with twins. She was discharged 24 hours after delivering preterm twins, and her husband was advised to move all their belongings on delivery day, out of borough and into a rural village on the edge of town. Her account with consent is written via a French Interpreter.

***“WHILST SHE WAS GIVING BIRTH,
HER FAMILY HAD TO LEAVE***

the first temporary accommodation and move into a new, larger temporary home (two bedrooms, a living room, and a kitchen). This new house had a

WOODEN SPIRAL STAIRCASE

leading to the bathroom and upper floor. After returning home from a caesarean section, it was not ideal for her to be going up and down the stairs due to the surgery, especially with twins, and there was no protection on the stairs for her 3-year-old daughter. She was given painkillers and injections to administer herself. At that time, the midwives also informed her that she could remove the dressing from the caesarean incision the next day.



One day after she returned home, she received a call from a midwife who said she was downstairs and had come for her checkup. Unfortunately, the midwife was at the old address, because no one had communicated the new address. She explained over the phone that she had moved and provided her new address. The lady then said she would come an hour later, no one arrived, she called the same number that had contacted her, but no one answered. She says how [Angie] visited and realised the babies had not been seen and immediately called and reported the missed discharge.

SHE WENT WITHOUT ANY VISITS FOR OVER 9 DAYS

from the midwifery team.

In the end, a lady arrived on Sunday evening at 5:00 PM and advised she needed to do blood tests on the twins, checked their weight, and a general check-up. She was advised once the results were in, she would contact her. This happened at 8:00 PM, when she received a call from the midwife asking her to go to the hospital immediately with one of the babies, as the blood test results were concerning.

ONE OF THE BABIES HAD JAUNDICE.

She went to the hospital with both babies because she was breastfeeding and couldn't leave one behind. Her husband remained with their daughter.

Once they arrived at the hospital they stayed there for two days. The baby was placed in an incubator for 24 to 36 hours. The doctor came to see her and informed her that it was necessary to give the baby a top-up because they

were unable to stabilise his blood levels. Once the results were good, they were able to leave the hospital. The following day, they had a visit from a healthcare assistant who came to check the babies' weight. The babies' weight had decreased since birth. When visited by [Angie], the support was very helpful, she is extremely grateful.

ANGIE REASSURED HER A LOT

about the basics related to pregnancy and babies, arriving here with nothing, and up until the birth of the twins, she didn't have any clothes or baby supplies (diapers, cushions, blankets). The money she received was only enough to feed her family — her husband and her 3-year-old daughter — and to attend her hospital appointments. [Angie] helped her and brought her diapers, Moses' baskets, blankets, and even a teddy bear for her 3-year-old daughter.

THE SUPPORT PROVIDED BY THE CRIB WAS INDESCRIBABLE,

and she recommends the service to all women in similar situations because,

WITHOUT THE CRIB, ONE OF HER BABIES COULD HAVE LOST THEIR LIFE."

—Sara's experience via an interpreter



Lack of governance and failure to ensure every contact counts and procedures are robust enough can lead to care not being handed over to the appropriate maternity, health visitor and social care teams. This has led to failings in care and more timely or avoidable readmissions. This family did raise the alarm and advised of the change of address; however, their care was not handed over, and the need for a primary visit was missed. These outcomes reflect the dangers of siloed systems, in this instance, where housing and health services communication processes failed. Neonatal jaundice, if not treated, can lead to permanent brain damage and central nervous system damage, a condition known as kernicterus.

The reality is clear: discharging mothers and babies into unsuitable accommodation undermines recovery, jeopardises infant health, and erodes family resilience. Hospital discharge must be recognised as a critical point of vulnerability, requiring coordinated and compassionate responses that prioritise safety, dignity, and continuity of care.

Perinatal Mental Health, Trauma & Shame

Homelessness during pregnancy is not only a physical and social crisis; it is profoundly psychological. Women navigating temporary accommodation often live in a cycle of fight, flight, freeze, or flop. They are constantly alert, fearful, and destabilised.⁵³ Chronic stress can erode resilience and undermine mothers' confidence at a time when emotional stability is vital.

Stress impairs the wellbeing of mothers and babies, whilst the emotional support of close others has been shown to buffer

stressors faced in pregnancy.⁵⁴ When this network is overseas or unavailable to support in person, women who do not speak English as a first language can become socially isolated and vulnerable to fluctuations and deteriorations in mental health.

At Shared Health, our practice-based experience observes how the cultural norms and expectations around birth, reluctance associated with talking about negative experiences and the ways in which women understand mental health vary significantly, frequently layered with shame that is associated with cultural beliefs regarding mental health and its origins. Support and care can be welcomed, but are most effective when relational trust and support have been established. Specific attention needs to be made to language, interpreters' gender, and time allocated to ensure interventions and support are explained and understood.

Please let me introduce Sadia, joining her husband in the UK from Bangladesh and expecting her first baby. Following a normal pregnancy, she was taken into hospital for an induction of labour. Antenatally, her mental health had been stable, although she was lonely and missing her family. Following a failed induction of labour and an emergency caesarean section, her baby was transferred to NICU following meconium aspiration. Her baby girl was very ill, and the prognosis was poor to begin with.

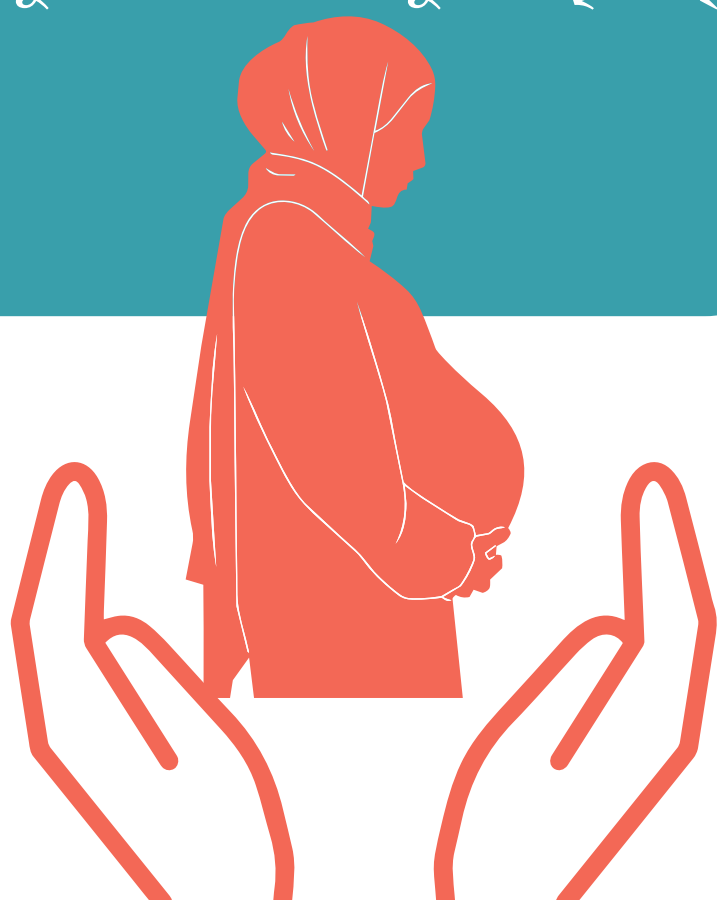
Sadia was completely traumatised and vacant when I arrived the day after delivery. Sadly, the first thing the midwife said when I requested a review advising this lady was presenting in a completely dissociated way, eyes glazed, tears streaming down her face, whilst she sat rigid and guarding her abdomen on the

bed, it was unfortunate the midwife stated, “they had not been able to get on top of her pain since recovery” This is repeatedly mentioned in reports that highlight the lived experience of black and brown mothers in the UK.⁵⁵

Thankfully baby made a miraculous recovery and came home 9 days following delivery.

জীবনরে খুব খারাপ সময় যাচছিলো। আপনার সহায়তায় এই সময়টা সহজে কাটিয়ে উঠতে পারছি। আমরা আমাদের প্রতিটি পদক্ষেপে আপনাকে সাথে ছিলো। আমাদেরকে সাপোর্ট করছেন মনেটালি অনেক বশে। আপনার সাথে কথা বলে মনে শান্তি কাজ করে। আপনার আন্তরিকতা আপনাকে অনেক কাছের আপন মানুষ মনে হয়। আপনি যখন আমাদের জড়িয়ে ধরেন আমরা অনুভব করি আমার বড় বোন আমাদের জড়িয়ে ধরছেন। অনেক শান্তি লাগে মনে। আপনি হাতে ধরিয়ে শখিয়ে দিয়েছেন কতবার প্রগেন্থানসতি ভালো থাকা যায়। আপনি মনেটালি যেন সাপোর্ট আমাদের দিয়েছেন তা আমরা কখনো ভুলব না। আমার মনে আছে আপনি আমাদের কে হাসপাতাল এ ৩/৪ দিন দেখতে গিয়েছিলেন। আপনি আমাদের বুঝিয়ে বলছেন কতবার ব্রস্ট ফিডিং করতে হয়। আমি নতুন মা হয়েছি এসব কিছুই আমার অজানা। আপনি আমাকে নিজের আপন মানুষের মত করে বুঝিয়েছেন সব কিছু। আপনি আমার পাশে বসে আমাকে পানি পান করছিলেন। জেনো আমি পর্যাপ্ত পানি পান করতে পারি। বার বার খুব সুন্দর করে বুঝিয়ে বলছেন বাচ্চাকে বুকের দুধ খাওয়ানোর উপকারিতা, পানি বশে করে পান করতে হবে, পর্যাপ্ত ঘুমতে হবে। আপনার এই ছোট ছোট যত্ন আমি কখনো ভুলব না। আমাদের কস্টের সময় আপনি আমাদের পাশে দাঁড়িয়েছিলেন। যদিও এইটা আপনার কাজের অংশ কিন্তু আপনি তার থেকেও বেশি করেছেন আমাদের জন্য। আমরা কথা বলার ধরন খুব যত্নশীল। আপনি অনেক ভালো মনে একজন মানুষ। আমরা খুব কৃতজ্ঞ আপনার কাছে।

তাকিয়া তাসলমি প্রিয়



“I was going through a very bad time in my life.

WITH THE CRIB’S HELP, WE WERE ABLE TO OVERCOME THIS TIME.

You were with us in every step of our way. You supported us mentally a lot. Talking to you brings peace to my heart. Your sincerity makes me feel like a very close person. When you hug me, I feel like my elder sister is hugging me. I feel a lot of peace.

YOU HELD MY HAND AND TAUGHT ME HOW TO BE GOOD IN PREGNANCY.

We will never forget the mental support you gave us. I remember you visiting us in the hospital for 3 or 4 days. You explained to me how to express and breastfeed.

I AM A NEW MOTHER, AND I WAS UNAWARE OF ALL THIS.

You explained everything to me like your own person; you sat next to me and helped me drink water so that I could drink enough. You have repeatedly explained very beautifully the benefits of breastfeeding the baby, that you should drink more water, eat well and that you should get enough sleep. I will never forget these small acts of care from you. You stood by us during our hardships, although this is part of your job, but you have done more for us. The way you talk to us is very caring. You are a very kind-hearted person. We are very grateful to you”.

– Sadia

Sadia's story reflects the need for trust and connection, so valuable to women who are so far away from who they would turn to for support and guidance around the birth. Following the safe discharge home, they forwarded a message from their daughter expressing further the depth of support they received and her father's experience. He had broken down in tears in the NICU. He had not told his family how desperately ill his daughter was, as he did not want to welcome negative talk over her life. The wait for him to provide a safe home and a place to bring his firstborn was especially difficult as they watched her on a ventilator and were unable to hold her.

Isolated and alone fathers' mental health in the perinatal period is also rarely inquired about, and concern is reported in guidance from the 1,001 Critical Days Foundation regarding the increase in paternal suicide.⁵⁶

"My mom tells me your story. How you helped and supported my parents mentally. You are very kind. And you taught my parents a lot. You taught my mother how to breastfeed. How many times did you visit me in the hospital? You hugged my mother when I was in NICU. My father broke down in tears with you, and you comforted him. And you also gifted me a lot, including my blankets and Moses basket. My mom shares everything with me.

***I AM VERY GRATEFUL TO YOU
& LOVE YOU A LOT."***

–Baby's voice



Perinatal mental health outcomes are stark, and a repeated theme through the MBRRACE-UK reports is not only for those who deliver and take home a baby but also for those who have a loss experience. The loss of a baby, whether through a bereavement or custody loss, often means many have no professional support or oversight from a specialist team. The expansion of perinatal mental health teams in 2019 gave hope to a developing service, but continued findings reflect that many were just not referred, and those who were went on to be declined support, as they were no longer pregnant or no further appointments were scheduled, due to a single missed appointment. Further research is required to understand the extent of barriers for homeless pregnant women living in temporary accommodation and perinatal services.

In addition, homelessness and maternal suicide remain an area for further research, as insufficient or inconsistent reporting means data sets are unreliable. However, maternal suicide is a leading cause of death in the perinatal period, and the women lost during these tragic endings deserved further awareness and services to support. Shared Health's work has contributed to the evolving work of MBRRACE-UK,⁵⁷ and the addition of questions around insecure housing for reporting data on infant deaths will support accurate data sets and support further exploration of how homelessness compounds risk factors such as isolation, poverty, and domestic violence.⁵⁸ Infant mortality and morbidity can exacerbate concerns around mental health and are heightened when families lack safe housing and adequate support.

Two emotive themes emerge repeatedly for pregnant homeless women:

Trauma: Pregnancy can amplify past adverse childhood experiences (ACEs) and trauma. Without sensitive, trauma-aware support, women may feel judged or unseen, reinforcing shame and isolation.

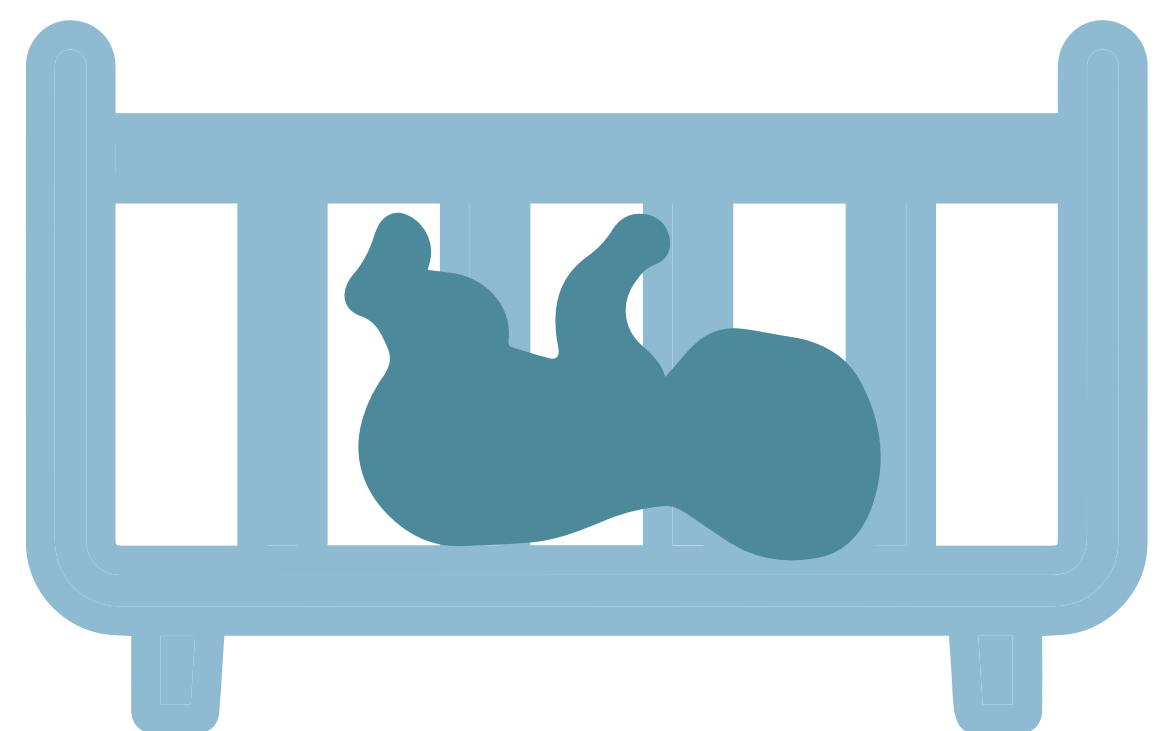
Shame: Many mothers describe feeling invisible to services, ashamed of their circumstances, and reluctant to disclose housing instability for fear of social services involvement. Shame becomes internalised, leading women to believe they are failing as mothers, even when their struggles stem from systemic barriers.

The emotional toll of being discharged from hospital into emergency accommodation illustrates this vividly. Women recovering from birth, often major surgery, are placed in rooms designed for short stays, often without kitchens, visitors, or safe sleeping arrangements for their newborns. Our families' experience is not in isolation, with even paternal fathers and extended family routinely excluded due to housing allocation rules. The result is isolation at the very moment when connection and support are most needed. Shared Health's Infant Parent Project, The Together Service, highlights the negative outcomes related to infant attachment and the journey for mothers through different types of temporary accommodation.⁵⁹

Safer Sleep Guidance, Cot Campaign & Strategic Change

The road to strategic change is slow and arduous, and practising midwives may not feel encouraged to change the system or even rock the status quo in their practice setting. It is rare, with only 3% of midwives going beyond first-degree level in academia,⁶⁰ and those going into research are minimal. However, a rich depth of experience and knowledge can contribute when placed in a catalyst organisation such as Shared Health. A unique advantage to see the unseen and adopt the principles and frameworks from their clinical and professional experience can support pilot projects, finding practice-based solutions.

One example of this innovative work is Shared Health's commitment to safer sleep practice for families in temporary accommodation, and the Cot Campaign originated from the work on the ground.⁶¹ Identifying this primary barrier to accessing the vital yet expensive equipment necessary to follow safer sleep guidance when in temporary accommodation, action was taken to drill down into the lived experience of our families and the barriers they faced. Depicted below are some of the larger steps towards changing the experience of the families themselves, services, practical access to equipment, but also the persistent steps required to ensure strategic change.



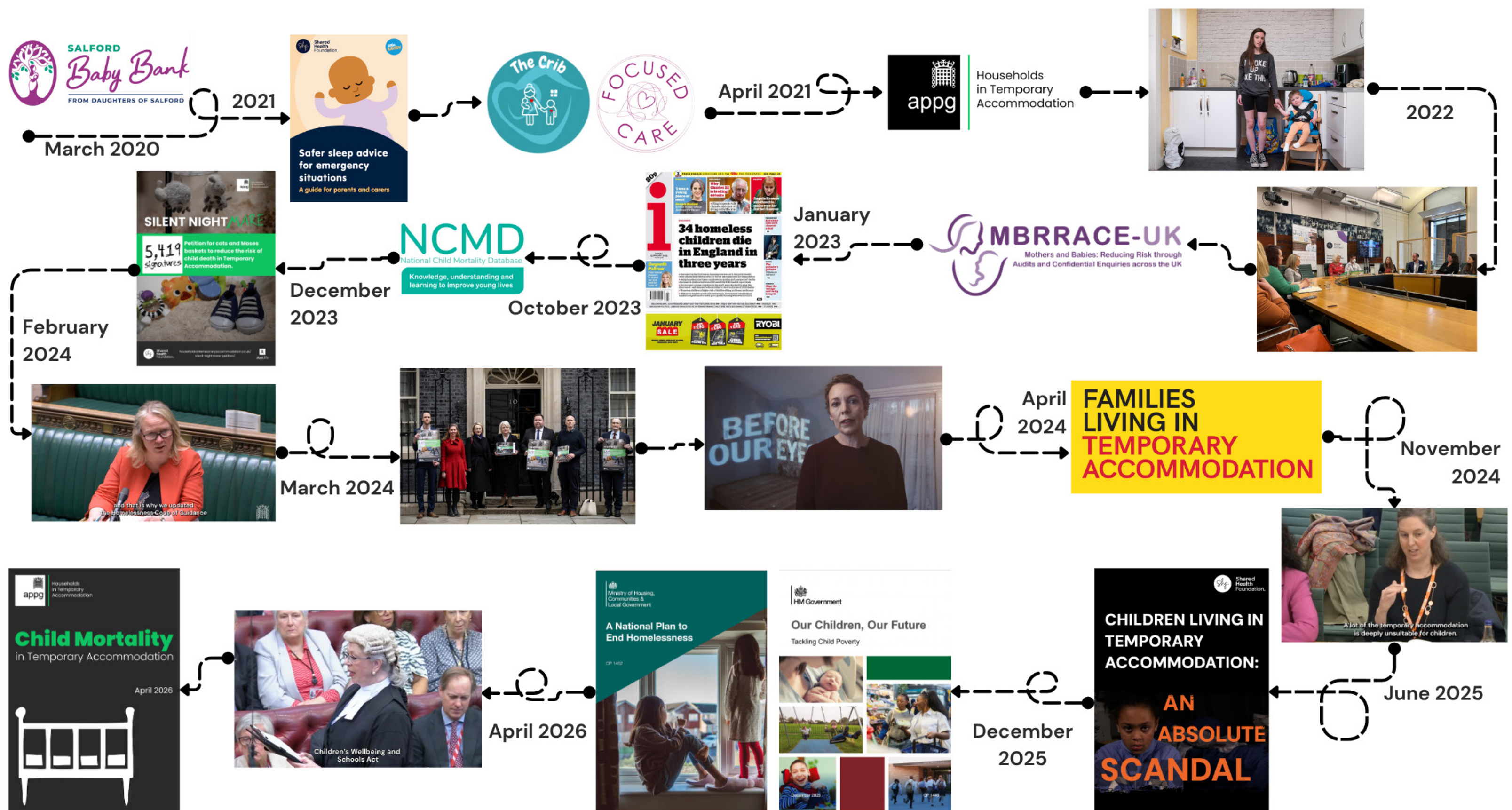


Figure 7: Trail of Change – illustration of the steps taken in campaigning for policy change for families and children in temporary accommodation

A Mother's Voice, 3 years after meeting her on her journey in homelessness after baby loss:

"From me finding out I was pregnant 2 years ago whilst being homeless, to
LOSING THE SAME BABY

JUST 4 MONTHS AFTER HE WAS BORN,

you have always known what to do or what to say, you're so professional but also so loving and nurturing, like a mother, I guess, you have been there in times of absolute distress and always been able to keep me from failing. I could not appreciate you more than I already do. You're amazing, thank you for always being my shoulder to cry on, but also letting me share my joy with you. Thank you for staying with me whilst I went through one of the hardest things life has thrown at me. Thank you for being strong for me,

MORE THAN JUST A MIDWIFE, YOU'RE A GODSEND.

Thank you for not giving up on me when I needed someone to blame & took my anger out on you when my baby passed away & just picking up where we left off when I came and found you again"

– Charlotte, 2025

Practical Items & Safety Equipment – Baby Banks: A Necessary ‘Emergency’ VCSE Service

The arrival of a baby brings practical necessities: a safe place to sleep, nappies, formula, and clothing. For families in temporary accommodation, these essentials are often out of reach. Rooms may lack space for a traditional cot, housing providers rarely supply basic infant equipment, and financial hardship forces parents into impossible choices like unsafe sleep practices and sometimes having to choose between being warm or hungry.

During the COVID-19 pandemic, baby banks emerged as a lifeline to families in crisis, originating mostly from charities and faith organisations. Much like food banks, they provide emergency supplies for families in crisis. By 2024, the Baby Bank Alliance estimated over 400 baby banks across the UK, responding to more than 155,000 referrals and distributing 3.2 million essential items. These provisions are not simply about nappies or formula; they are about prevention of further harm, dignity, safety, and the ability to follow professional guidance and public health advice.

Local authorities’ reliance on resources provided by VCSE enables front-line workers to resource those families in extreme hardship, and demand is unprecedented, with many midwives, health visitors, social workers and housing officers increasingly relying on baby banks to support their most vulnerable families. The growth of these services reflects both community resilience and systemic failure. Where statutory provision falls short, voluntary and faith-based organisations now routinely step in to ensure that no baby is left without a safe place to sleep.



Summary

Pregnancy is a time when safety, stability, and care should be guaranteed, but for thousands of women across England, it coincides with the instability of the cost-of-living and housing crisis. The evidence presented in this report demonstrates that homelessness is not only a housing issue but a profound health inequality, shaping maternal outcomes, infant development, and family wellbeing.

The stories of women discharged into emergency accommodation, moved during labour, or left without space for a cot are not isolated incidents — they are systemic failures. They reveal a welfare system that too often prioritises numbers over compassion, and housing stock over human dignity.

At its heart, this report calls for recognition: recognition that stable housing is a basic human right, that pregnancy magnifies vulnerability, and that the unborn child must be considered in every statutory framework. It calls for reform that embeds housing within maternity care, ensures continuity of support, and equips professionals to assess both social and clinical risk factors and respond with curiosity and compassion in every pregnancy.

The resilience of families navigating homelessness is extraordinary, but resilience should not be demanded in place of rights. The responsibility lies with national policymakers, local authorities, and professional bodies to act decisively. By aligning housing provision with maternal and infant health priorities, by supporting baby banks and community networks, and by reforming legislation and calling professional bodies to address the theory-practice

gap for all new students, we can begin to dismantle the barriers that leave mothers and infants unseen.

This is not simply about statistics or services. It is about the lived experience of women who carry both the weight of pregnancy and the burden of homelessness. Their voices must guide us; their needs must shape policy, and their unborn children must be at the centre of our collective responsibility and decision-making.

Shared Health Foundation dares to hope that we can move from a system of fragmented responses to one of compassion, dignity, and justice for homeless pregnant women and their families. Where each baby born is given a world of opportunity to thrive, not merely survive.



**Do the best you can until
you know better.**

**Then when you know better,
do better.**

Maya Angelou



Recommendations

- 1 Legislative Reform:** Strengthen housing law to explicitly protect pregnant women and infants, ensuring temporary accommodation meets minimum standards for safety, nutrition, and infant care.
- 2 Mandatory Housing Status Recording:** Require maternity services to document housing status at booking, 28 weeks, 36 weeks, delivery, and postnatal discharge. This would embed homelessness as a recognised social risk factor in clinical decision-making.
- 3 Ministerial Responsibility:** Establish a Minister for Children and Families with a statutory duty to consider the unborn child's voice in housing and welfare policy.
- 4 Integrated Health Programmes:** Introduce a national "Health MOT for women", a prevention programme for homeless women between pregnancies, focusing on nutrition, mental health, access to universal screening, family planning and safeguarding, ensuring all are ready for pregnancy.
- 5 Funding Ringfence:** Align local authority responsibilities with the NHS 10-year Plan, ringfencing resources for midwives and health visitors to provide the finance required to ensure a workforce and commitment to continuity of care, specifically in areas of deprivation with high levels of homelessness.
- 6 Continuity of Care Pathways:** Develop responsive, dynamic care models for pregnant homeless women, ensuring longer appointments and trauma-informed practice.
- 7 Baby Bank Partnerships:** Formalise collaboration between local authorities and baby banks, recognising them as essential emergency welfare provision supporting front-line services.
- 8 Safe Discharge Protocols:** Guarantee that families are not moved during labour or immediately after birth, and that out-of-area placements, including better governance and procedures around discharge, especially if out-of-borough communication is required.
- 9 Nutrition Standards:** Ensure temporary accommodation provides access to cooking facilities, refrigeration, and safe food storage to reduce reliance on ultra-processed foods.
- 10 Safeguarding Oversight:** Embed housing considerations into safeguarding frameworks, recognising that unsafe accommodation is a direct risk to maternal and infant health.



Professional Bodies and Education

- 11 Curriculum Reform:** Integrate modules on the social determinants of health, homelessness, and trauma-informed care into midwifery and medical training.
- 12 Professional Development:** Align Royal College of Midwives (RCM) proficiencies with current trends and the realities of the theory-practice gap, equipping practitioners to identify and mitigate barriers to care and build a resilient workforce.
- 13 Cross-Sector Collaboration:** Encourage creative partnerships between health services, housing providers, and voluntary organisations, breaking down stereotypes that leave families unsupported.
- 14 Research Investment:** Prioritise studies on nutrition, perinatal mental health, and infant outcomes in homeless populations to close evidence gaps, inform policy and develop best practice guidance.

Woman: the words “woman” and “women” have been used throughout this document as this is the way that the majority of those who are pregnant and having a baby will identify. For the purpose of this report, this term includes girls. It also includes people whose gender identity does not correspond with their birth sex or who may have a non-binary identity.







The Crib Data Summary

October 2025 – May 2026

General Information

	Referrals	Accepted			Active	Discharged	Disengaged with service
		In EA	In TA	Total			
Totals	72	26	27	70	46	17	8

Household Members At Referral

	Total in household	Single Female	Single Male	Couple	Family	Pregnant at referral	Children in household					
							0–2	3–5	6–10	11–16	16+	Total
Totals	153	37	3	25	5	20	22	29	12	17	8	100

Resources Shared at Referral

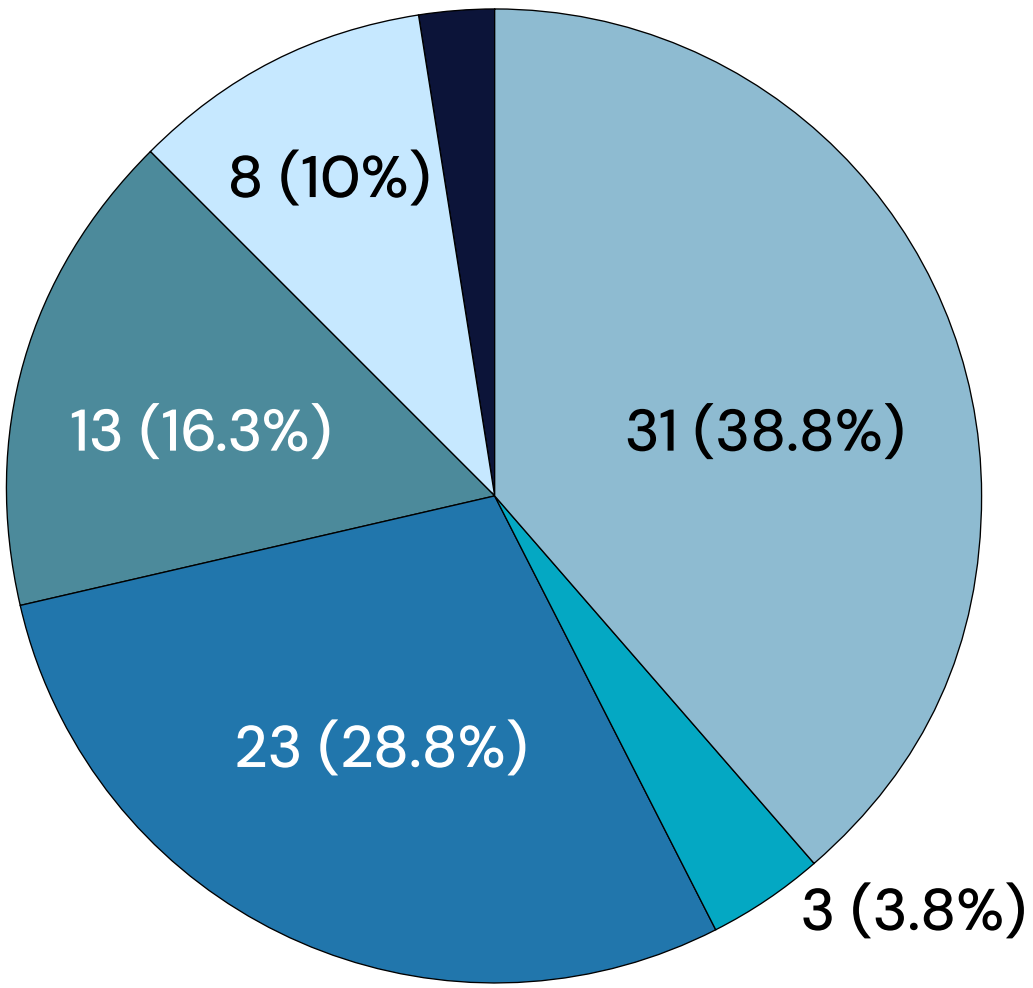
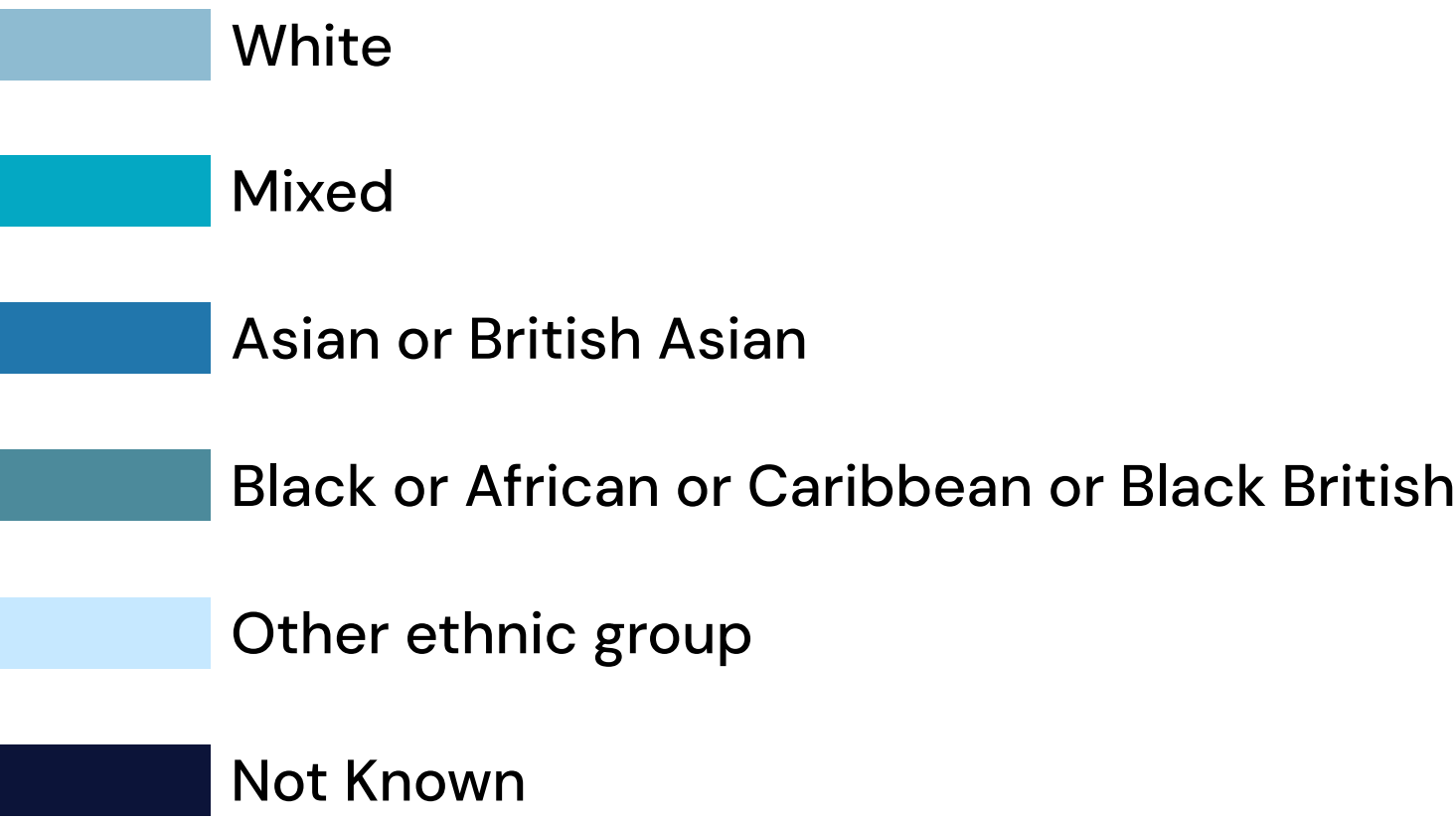
	Food Bank	Baby Bank	Healthy Start		Safer Sleep			Hygiene Essentials			Infant Formula	Washing Facilities
			Mum Vitamins	Infant Drops	Advice/ Leaflet	Moses Basket	Cot	Baby	Family	Delivery Pack		
Totals	10	22	10	7	5	5	0	8	16	2	2	26

Resources Shared at Follow-Up

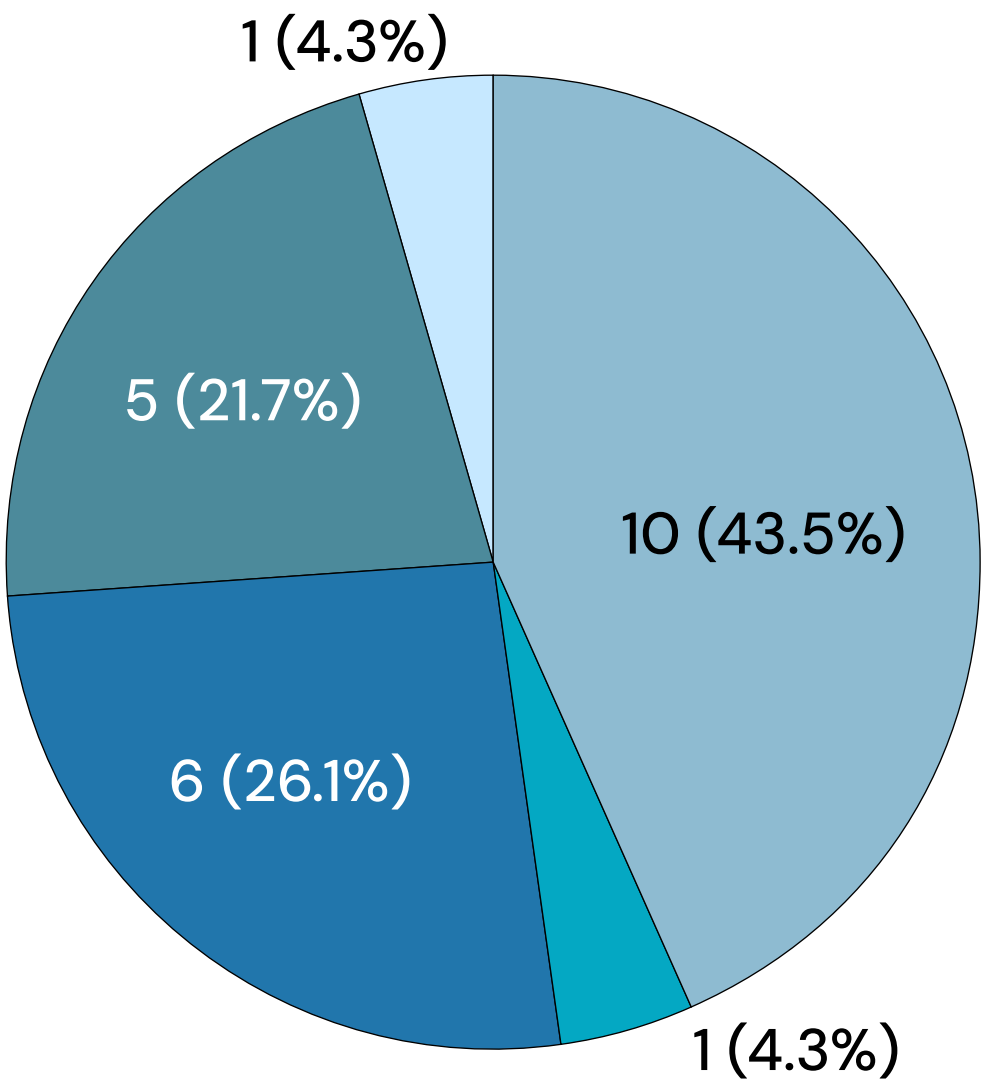
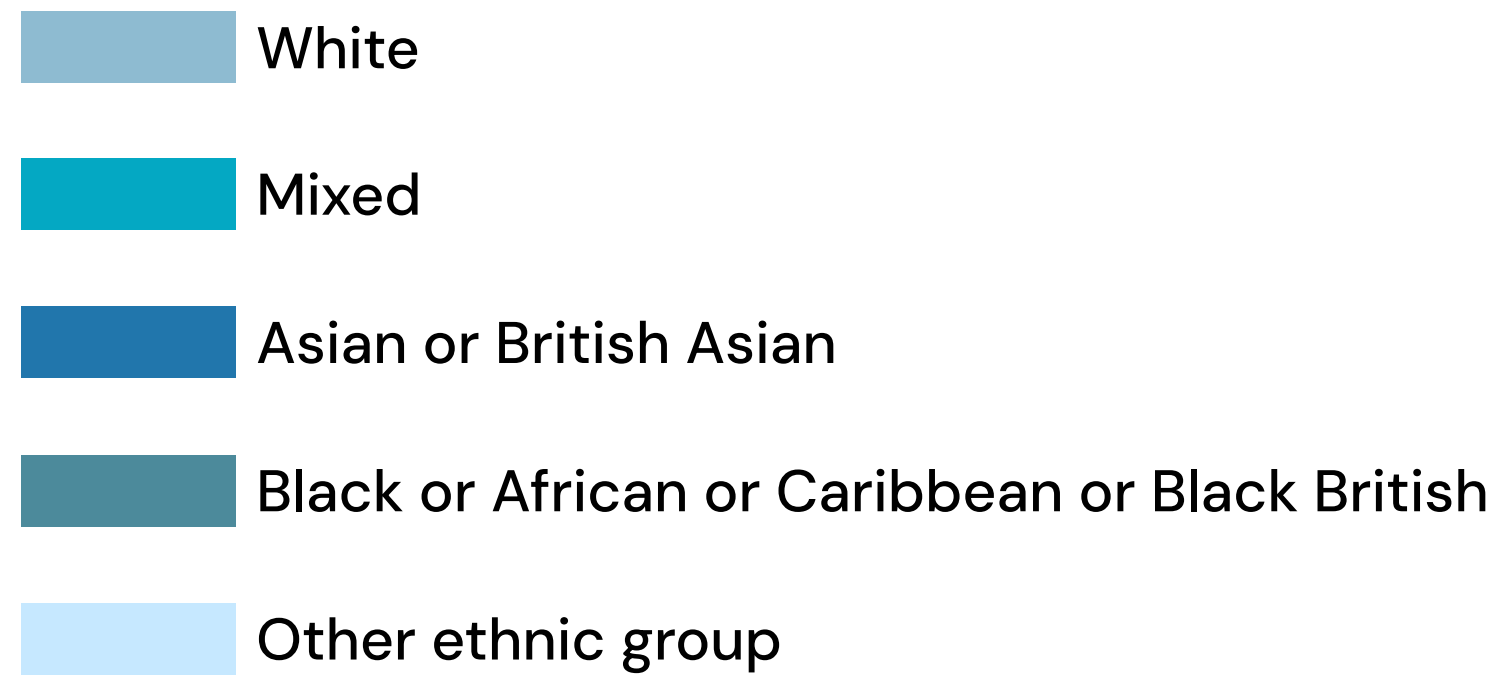
	Food Bank	Baby Bank	Healthy Start		Safer Sleep			Hygiene Essentials			Infant Formula	Washing Facilities
			Mum Vitamins	Infant Drops	Advice/ Leaflet	Moses Basket	Cot	Baby	Family	Delivery Pack		
Totals	21	29	17	14	20	16	6	44	59	17	5	118

Breakdown by Ethnicity

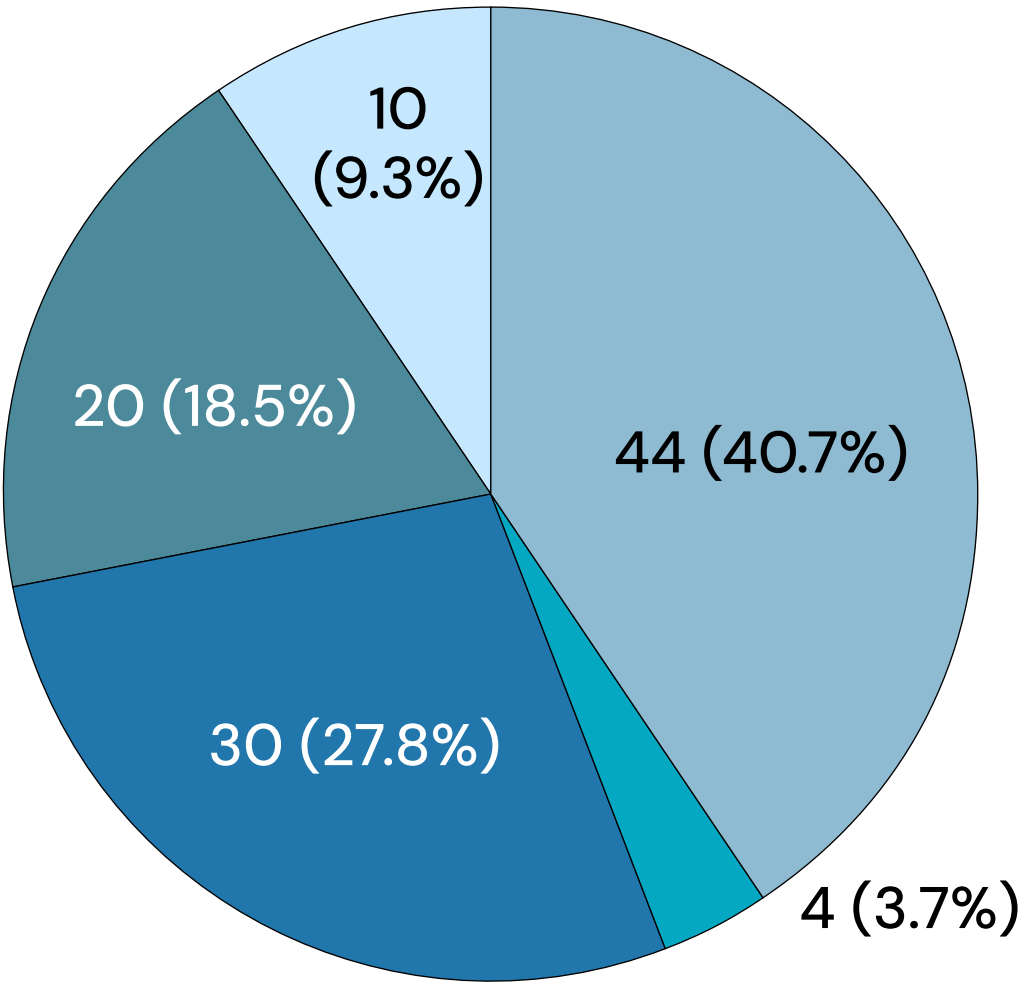
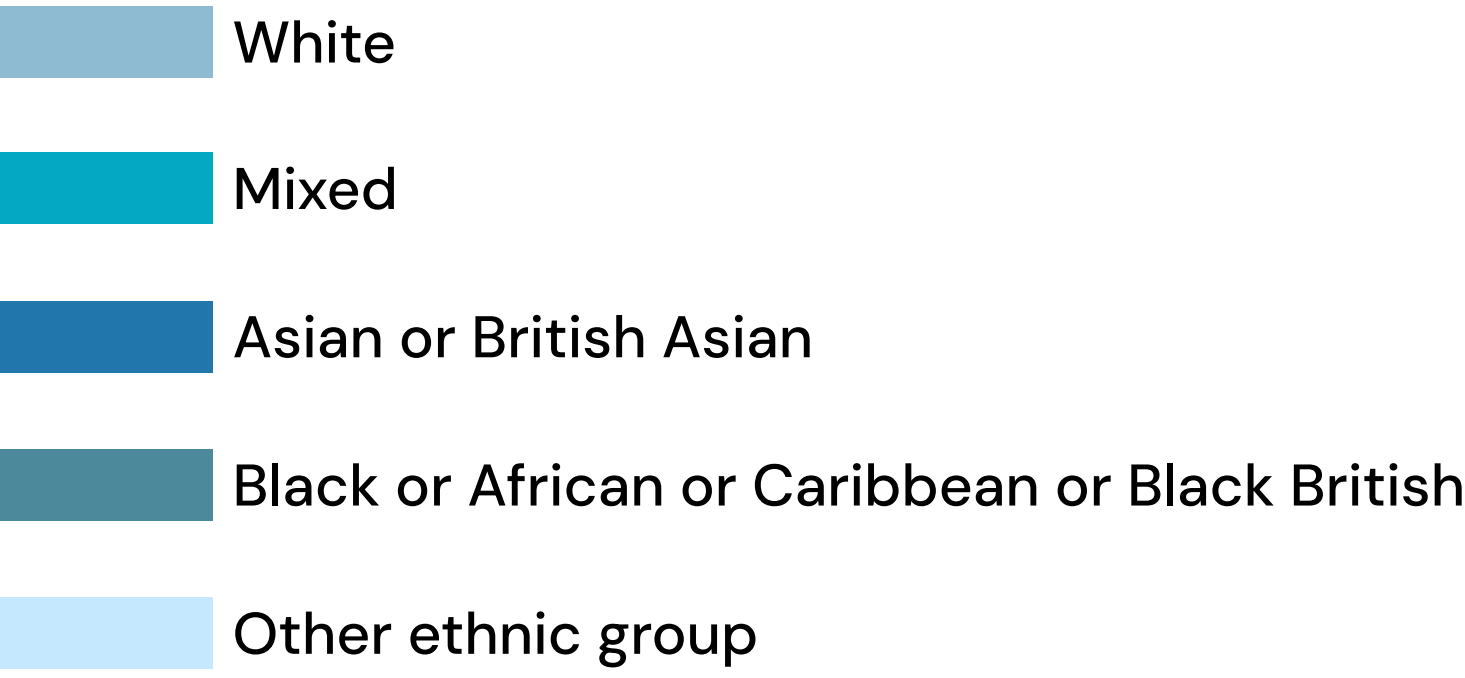
Ethnicity of Patients



Pregnant at Referral



Number of children



Breakdown of pregnant patients

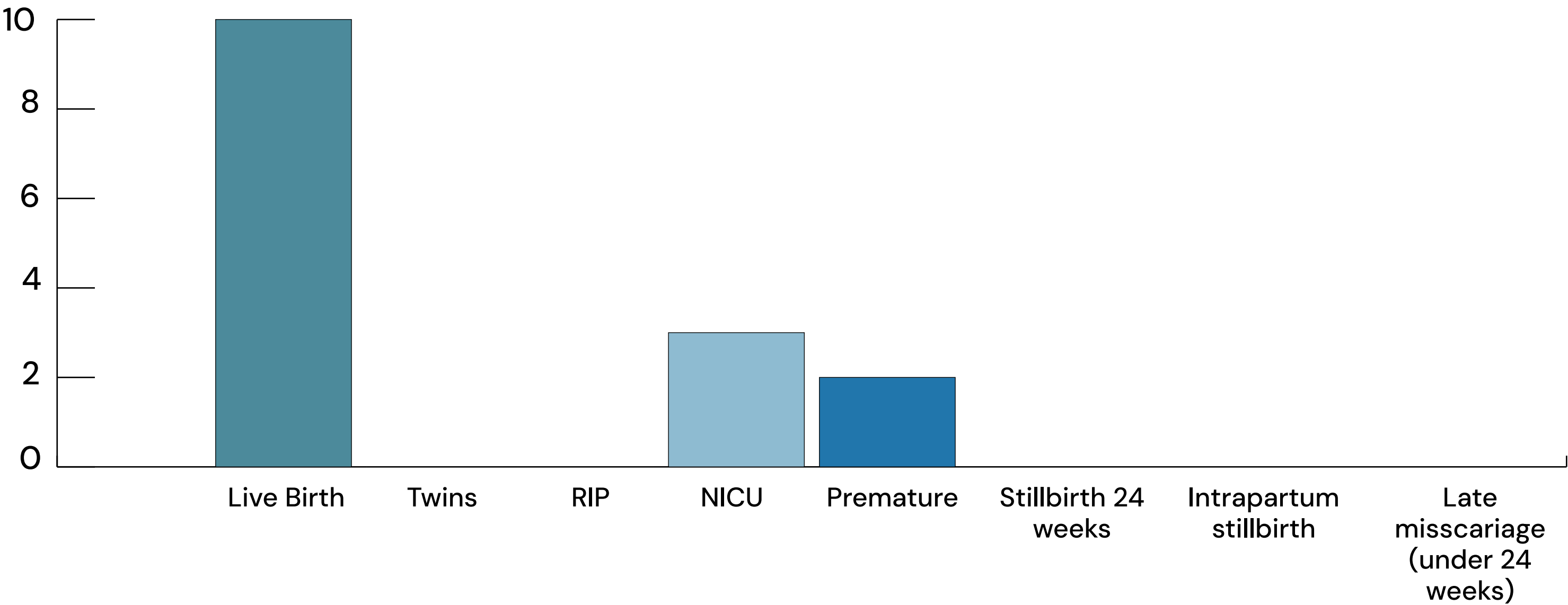
Pregnant women born in the UK

Includes pregnant at referral only, follow-up only, and at both referral and follow-up



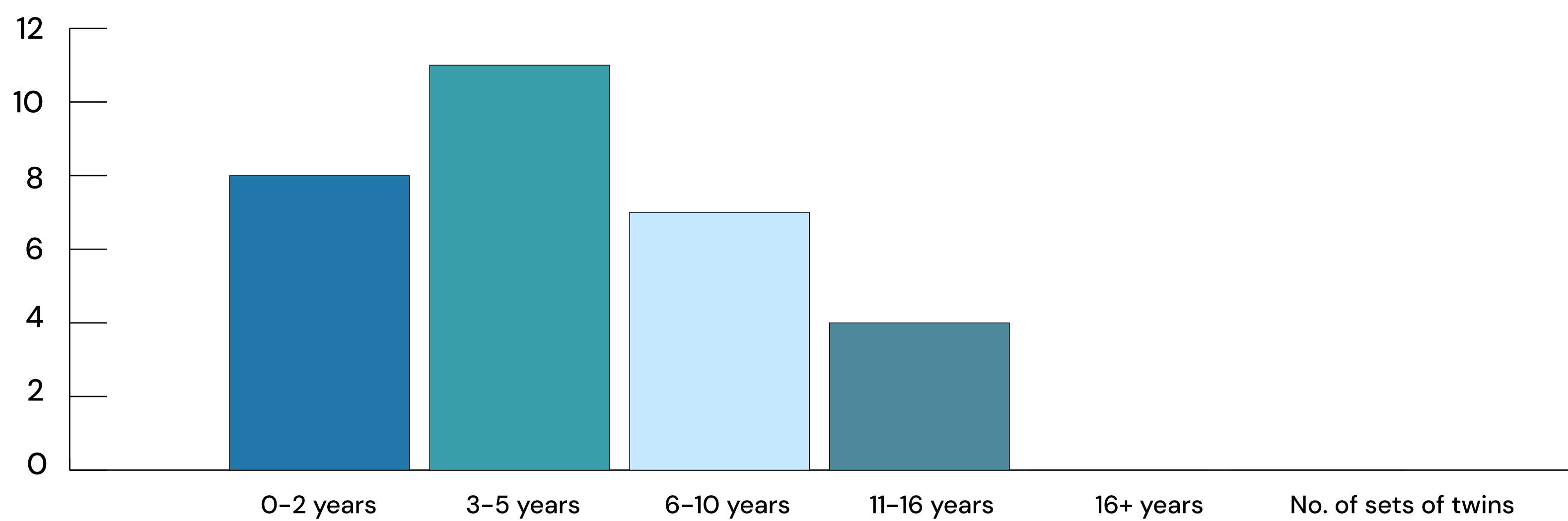
Pregnancy Outcome

Pregnancy outcome for patients pregnant at time of referral who give birth during their time with The Crib

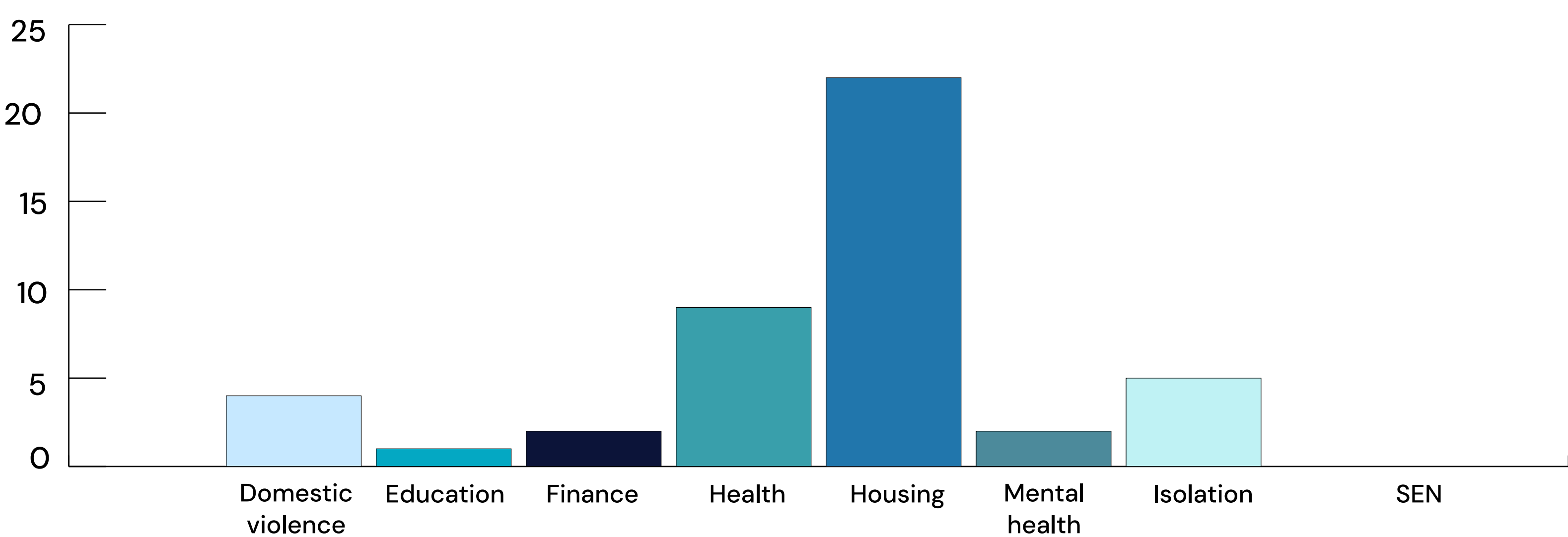


Number of Children

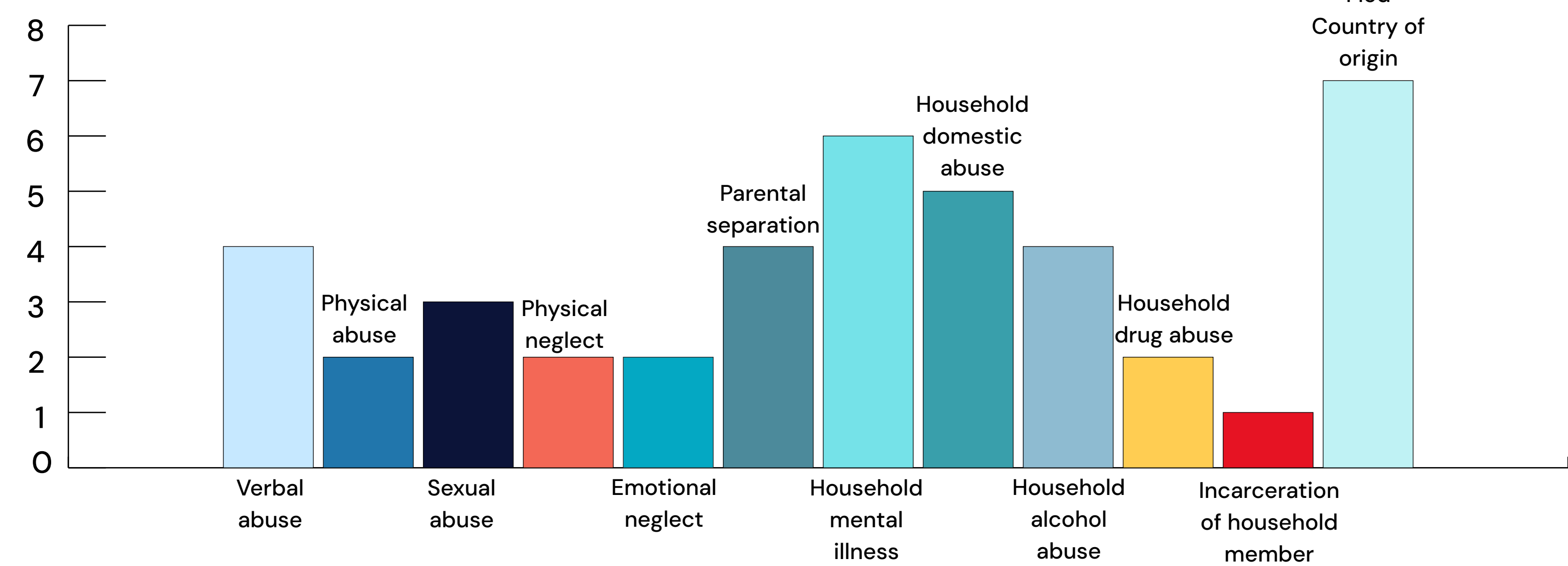
Total number of children pregnant women have at time of referral



Family's Priority Concern



Adverse Childhood Experiences of Pregnant Women



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