Opinion Feature

Title: Healthcare Access Barriers Faced by Pregnant Women Experiencing Homelessness in the UK

Author affiliations

Professor Monica Lakhanpaul, UCL Great Ormond Street Institute of Child Health, University College London (UCL), UK; Follow Monica on X (formerly Twitter): @ProfLakhanpaul

Dr Nadzeya Svirydzenka, De Montfort University, Leicester, UK; Follow Nadzeya on X (formerly Twitter): @Svirydzenka

Introduction

Rising homelessness in the UK (Crisis, 2024) continues to pose significant challenges to health and well-being, with pregnant women representing a particularly vulnerable demographic. Key vulnerability factors affect their access to healthcare services, likely to increase both immediate and long-term health and wellbeing risks for both mothers and babies, and thus require urgent and systemic support. It is important to also note that pregnant women experiencing homelessness are not a homogeneous group and are likely to be affected by a unique intersection of vulnerabilities linked to homelessness, including demographic factors and personal histories (e.g. ethnicity, trauma and abuse history, migrant/refugee/asylum seeker status, additional care responsibilities). Therefore, interventions and services need to be flexible not only to the complexities of homelessness, but also the women's diverse life journeys and histories. While existing policies and guidelines recognise the role of homelessness in health, they are rarely based on evidence-based research co-created with such vulnerable groups, instead making assumptions about their contexts and needs and not accounting for unique lived experiences framed by homelessness.

Barriers

For pregnant women experiencing homelessness, living (and frequently moving) between temporary accommodations or women refuges, or rough sleeping and sofa surfing, getting through the door of services is a primary challenge. Knowing where to get support is one issue, but our research shows that women are also discouraged from coming forward due to fears of discrimination for their homeless status, and power discrepancies in the medical context. While not a legal requirement, most GP surgeries require proof of address for registration, for example. Thus, without a stable address, pregnant women might access care late in their pregnancy, missing key scans or early interventions. Monitoring due to changes in care team as a result of registration gaps might also be inconsistent if women are moved frequently during their pregnancy. Additionally, reliance on public transport can make attendance challenging once they have access.

Furthermore, financial constraints limit access to necessary healthcare, medications, and nutritious food, all crucial for healthy pregnancies. Available homeless accommodation can provide limited food storage and cooking facilities. In addition, navigating access to healthcare benefits with limited internet and eligibility complications, especially those without documentation or with uncertain immigration status, is yet another barrier.

Finally, medical literacy and the capacity of pregnant women experiencing homelessness can serve as an additional obstacle. Firstly, mental health issues are common following challenges faced prior and during homelessness (like partner violence, traumatic migration journeys) and deter women from seeking care and support. Secondly, not knowing procedures or help points can prevent access to timely healthcare or educational resources for pregnancy. Thirdly, substance abuse and other maladaptive coping mechanisms can impact access and compliance with pregnancy medical support. Finally, family/community support which facilitates timely and consistent healthcare access via lifts to appointments or childcare during scans, are likely to be missing.

Recommendations

Importantly, existing good examples of practice can be scaled to address these systemic, financial, psychosocial, and support barriers.

First, outreach services, like mobile clinics, can deliver care directly to pregnant women experiencing homelessness, mitigating transportation, system navigation or GP registration issues. For example, Doctors of the World operates a mobile clinic in London offering flexible walk-in appointments to accommodate unstable timetables. Financial support via schemes such as Healthy Start can provide further help via providing vouchers for healthy food and vitamins.

Second, Integrated Health and Social Care teams comprising midwives, social workers, mental health professionals, and substance abuse counsellors provide holistic care tailored to pregnant women's needs. Pathway, a homeless healthcare team operating in several London hospitals, combines health and social care services, the Maternity Trauma and Loss Care Service (M-TLC) in Manchester provides vulnerable women with mental health support within care settings and the DAISY Project in Glasgow supports pregnant women with substance abuse issues. Additionally, legal support, such as The Homeless Families Project in Birmingham providing case management and advocacy and Shelter's support with navigating the benefits system, empowers women to effectively navigate available support systems.

Finally, sensitivity of frontline staff and their skills in trauma management can help dissuade discrimination concerns. Support from peer advocates, as illustrated by the Groundswell project, helps women assert their rights to access services. Peer group support via initiatives like St. Mungo's charity's programs where formerly homeless individuals support others in their position, are beneficial in early pregnancy, while community groups focus on labour and breastfeeding support.

Conclusion

Pregnant women who are homeless face numerous healthcare access barriers, significantly impacting their and their babies' health. Addressing these challenges requires a multifaceted approach, integrating healthcare with social support service improvements and addressing structural, financial, and psychosocial barriers. By enhancing maternity and post-partum care through targeted interventions and policies, and leveraging and scaling successful UK-based models, the UK can significantly improve health outcomes for this vulnerable population in the UK and internationally.

Currently 799 words (word limit 800 words)

Footnotes

Competing interests?

Possible support case studies to be included

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