MedCrave
Step into the World of Research
International Journal of Pregnancy & Child Birth

Research Article
Open Access
CrossMark

Perceived needs for a community based residential model of care for new mothers and babies

Abstract

Background: Women who have recently given birth are discharged after a short hospital stay have high and sometimes unmet needs for practical and emotional support. A community-based, fee-free domestic residential service has been provided by an experienced doula and there is now consideration of expanding and formalising the service. The aim was to ascertain the views of diverse interest holders about the needs for and nature of such services.

Methods: Semi-structured interviews with women who had or had not used the service, health care providers and managers. Data were analysed thematically.

Results: Of the five women who had used the service and five who had not, some favoured a residential model which allowed them to recover from the stresses of the pregnancy and birth, affording them uninterrupted time with their newborns. Others preferred to be home but sought attendance at an appropriately staffed centre to meet their peers, share concerns and acquire caregiving skills. A few preferred home help. Five nurses attending new mothers and their babies, three doctors, a senior clinical administrator and a volunteer identified safety, clinical standards, health regulations and costs as concerns to be addressed. Many women need assistance, especially if there was no family support, or affordable additional care. Potential adverse consequences affecting the health and wellbeing of women and their babies might be averted by new models of community-based care.

Conclusion: Diverse interest holders had aligned views that many women who have recently given birth have unmet needs for rest, support, opportunities for recovery and a reduced household burden. Opinions varied as to how to address these needs – though kind, supportive care in a domestic setting versus additional support at home. Fee-free services provided by volunteers are not sustainable. Affordability and equity of access are potential problems Health professionals agreed with the need but had concerns about safety and quality. Funding remains problematic and would require evidence about costs and benefits.

Keywords: mother, babies, postnatal care, dwelling space, maternal support

Volume 12 Issue 2 - 2026

Raie Goodwach,[1] Maggie Kirkman,[1] Margaret Hay,[2] Samuel Menahem,[3,4] Jane Fisher[1]
[1]School of Public Health and Preventive Medicine, Monash University, Australia
[2]Subfaculty of Health and Sciences, Monash University, Australia
[3]Department of Paediatrics, Monash University, Australia
[4]Murdoch Children's Research Institute, University of Melbourne, Australia

Correspondence: Samuel Menahem, Department of Paediatrics, Monash University, 246 Clayton Road Clayton, Vic, 3168, Australia, Tel +61 3 9509 1333, Fax +61 3 9576 1352

Received: February 07, 2026 | **Published:** March 25, 2026

Introduction

Over the last six decades, women's experiences with care following childbirth have changed substantially, from a hospital stay of at least five nights following unassisted vaginal birth, to much shorter stays of 24 - 36 hours. Stays following Caesarean birth are longer, but nevertheless at three to four nights are substantially shorter than the 7 - 10 days that used to be offered. Because of the reduced time in hospital, postpartum care has returned to the home, with a shift away from a medical model of care to a model of community care. Women who return home after one day may be visited by a midwife and all new parents in Australia have access to a maternal, child and family health nurse and a general practitioner (GP). However, intergenerational proximity is now more limited by geographic separation of parents and their adult children and women's participation in the paid workforce can mean that grandparents are not available to provide support. Paid parental leave has been a beneficial policy development, but paternity leave is time limited. Even when partners take time away from income-generating work to share household tasks and infant care new mothers may have insufficient time to recover from childbirth and establish routines of newborn care. It can be especially difficult when having also to care for older children. There is also an increasing group of mothers parenting alone. In these circumstances women can experience the newborn period as isolated and lonely and have limited access to support.

RF, a doula and experienced mother and grandmother offers care in her home for women who have recently given birth and their babies who are members of her Jewish community. A private room and meals are provided without charge. She is available for care when she is not away from home for her work as a doula, and women are able to stay as long as they feel a need to.[1] Now that the Australian norm is short stays in hospital with limited post-birth care her service prompted the question of whether there was a need for this type of residential service to be expanded more formally in Australia. As Smythe et al. argue, all mothers need a 'Dwelling Space' in their early days of motherhood.[2] Withanage et al. in an early evaluation of RF's service argue *"That 'space' may provide a woman a sense of being mothered, to let go, to feel replenished, to rest and to completely evolve into being a mother to her newborn infant prior to her return home"*[1]. This type of care is available in centres overseas for well mothers and their healthy babies where the need for rest and recuperation postpartum to promote maternal well-being, feeding and bonding is recognised. These services (which are not fee-free) are called confinement centres in Taiwan, Malaysia, and other Asian countries, in Vietnam, The Joyful Nest.[3] In New York City there is the Boram Postnatal Retreat and Israel offers the Baby Lis Boutique Maternity Hotel. There are no equivalent services in Australia.

Aims

The aims were to determine, in the setting of short postpartum hospital stays:

1. The service needs of women who have recently given birth and been discharged to the community.
2. Perceptions of the potential benefits and harms of dedicated residential care in a community setting for postpartum recuperation and mother/child bonding.
3. Mothers' and health professionals' views on a community-based model of residential care as an addition to existing health-based services.
4. Synergies and differences between an Australian and similar models of care internationally, and perceived benefits and challenges.

Methods

Participation in the research was sought from women who had used the residential care service (The Haven), women who had recently given birth but had not used the service, and health care professionals (medical practitioners, hospital administrators, midwives, and maternal, child and family health nurses). Flyers describing the research and calling for volunteers were distributed through The Haven, and in clinic waiting areas, at local general practices and maternal and child health centres. Health professionals were approached directly.

Potential volunteers were given a project information and consent form. Those prepared to participate signed and returned the consent form and were offered interviews in person or by Zoom. The questions asked of each group are appended. Appendix A contains questions for mothers who had not experienced residential care after leaving hospital; Appendix B contains questions for mothers who had experienced residential care after leaving hospital; and Appendix C contains questions for professionals.

The semi-structured interviews were audio recorded and transcribed. Transcripts were analysed thematically[4] by repeated reading of the transcripts to identify themes. Themes represented ideas, experiences or perspectives from participants' accounts and were derived from the responses to the open-ended questions and from the elaborated explanations that were contributed. As the same questions are asked of all participants, responses can be compared across interviews while still allowing new or unexpected themes to arise. MK and JF each read the transcripts and discussed and agreed on the themes and the quotations that illustrated these.

Approval to conduct the research was obtained from the Monash University Human Research Ethics Committee, project number 2025-36679-123827.

Results

Participants

Consent was received from five women who had used the residential service (RC 1 – 5), five women who had not used such a service (NC 1 – 5), and ten health care professionals (P 1 – 10). The health care professionals were five nurses who administered and provided various services for new mothers and their babies (P3, P4, P6, P7, P9), four medical practitioners (two GPs, a paediatrician, and a senior clinical administrator: P1, P2, P5, P8), and a volunteer home visitor for new mothers (P10).

The women who had used the residential service were aged 31 to 50 and had five to ten (one each of 5, 6, 7, 8, and 10) children. All had used the service for their most recent birth; a few had also used it after a previous birth. The women who had not used the residential service were aged 28 to 41; four had one child (plus, in one case, three primary school-aged step-children) and one woman had four children. All ten women had male partners.

Eight of the ten health care professionals were women. Where years of experience were given, they ranged from 20 to more than 30 years.

All twenty volunteers were interviewed. The interviews took between 30 and 60 minutes.

To maintain confidentiality, participants are reported using codes: RC for women who used the residential service (RC 1 – 5), NC for women who had not used the residential service (NC 1 – 5), and P for professionals (P 1 – 10).

Responses to research questions

All participants agreed that new mothers may be exhausted and many lack adequate support. There was consensus that women's needs and wants vary; some mothers preferred longer hospital stays whereas others preferred to go home as soon as possible.

Every mum's different. Some mums are dying to come home and just be in their own space, their own beds. Disadvantages to that would be just not enough time to get the knowledge across about how to deal with a baby; how to deal with their own health. ... If they don't have family, often they feel very alone when they come home, depending on their partner support. (P9)

Postpartum mothers' experiences of this phase of motherhood

Mothers who had used The Haven

Many had a history of differing postpartum experiences, frequently in other countries. Some had returned home after earlier births following a brief stay in a public hospital, perhaps with help from extended family and friends or with assistance from *"a girl"* (RC2) or a nanny (RC5). Others had an extended stay in a private hospital before returning home. They spoke of lack of privacy in a public hospital (RC4), unavailability of kosher food in a public hospital (RC2), gratitude for religious holiday observance in a private hospital (RC3), and returning home to dirty washing and other demanding household tasks, especially when the husband had no or inadequate parental leave or time away from income-generating work. One mother (RC4) was glad to go home to a familiar environment.

Mothers who had not used The Haven

They spoke mostly of good hospital care from both public and private hospitals. A few had experienced varied support and conflicting advice. NC2 would have liked a longer hospital stay than the five days she experienced but did not request it. Two (NC1 and NC2) had completed the five-night residential early parenting program at a local hospital, which is commonly referred to as a *"sleep school"* (NC1). One mother (NC3) had used RF as her doula but preferred her own bed to staying elsewhere. Friends had provided food for her on a roster. NC4 and NC5 both experienced good hospital care including assistance in establishing lactation. Home visits from the maternal and child health nurse had been welcomed. NC4 felt relaxed after her four days in a private hospital:

I was kind of in the room the whole time, and we just had music playing in the background. It was a very relaxed environment. ... We still had the [COVID] restrictions on visitors, which I think was

actually really helpful. … [The transition to home] was really lovely. … I was very ready to come home. … I had my partner at home for the week after we got back, and we also had my family, … And so I think a mix of having that support, having the house somewhat ready to have the baby, and yeah, it all helped. (NC4)

NC1 commented on being given conflicting advice in hospital and NC2 thought that the community nurses were too *"politically correct"* and afraid of making definitive statements.

It was a bit of a shock to me to see how, yeah, the aftermath of birth and the expectation on you, particularly with no family support around. I found that particularly hard and like… It took my mum to come over and see that we were doing it wrong or not doing everything. ... Having someone in your home setting, I think, would be really useful. (NC1)

NC5 was glad of a local mothers' group (these are arranged for primiparous women by the maternal, child and family health nurse in a local community centre) and was looking forward to their first gathering for the reassurance it promised:

I can talk with other mums that maybe they are in the same situation, because everything is new for me. And maybe I think that is not normal, but maybe if I talk with someone and they say, Oh, it happened to me too, or in my case, or something like that. And that is really cool. (NC5)

The benefits of a dedicated opportunity for postpartum recuperation and mother/child bonding in an era with short hospital stays

This research question and the next are closely associated. We have understood this question to refer to women's experiences, and the next to refer to a more general assessment of a community-based model of residential care.

The women who had used The Haven service did so after recommendations from others or because RF had been their doula (RC4). RC4 had specifically sought help from RF for mastitis. One mother (RC5) had used the service for her last three (of six) children. Their decisions were not straightforward and most were reluctant to spend all their time away from home. Mothers described RF as *"extraordinarily generous"* (RC1), *"sensitive and respectful"* (RC3), and as providing *"a safe space"* (RC3). RC4 was grateful for RF's *"validation"* of her as doing a good job as a mother. One mother summed up what it meant to her to go to The Haven:

With my youngest, I was at R's place for 2 weeks, … literally coming home a different person. … And I did have the, you know, couple of days in hospital. And I thought to myself, I'm feeling okay, maybe I'll go home. … be a bit with the kids before I go and stay at R's. … It was the biggest mistake ever. … It's not like I don't want my kids. I was very happy when they came to visit me by R, and they did come. … But when you're home you just can't relax, and you can't recover. (RC1)

Another mother (RC2) was glad to be able to sleep during the day at The Haven but missed her children, *"got sick of doing nothing"*, and was eager to go home. She enjoyed hearing RF's grandchildren come in after school. In her view, if you could afford a cleaner and a nanny it would be better to stay at home. She described RF as *"a wonderful doula"* and could not imagine giving birth without her.

RC3, did not want to *"abandon my kids"* and chose to sleep at RF's house but spend every day at her own home, saying *"I walked with the pram backwards and forwards."* RC4 was also conflicted about being away from home, although she was grateful for RF's kind care, which she accepted because she was *"overwhelmed"* by her other children. Although she found her room *"sweet, comfortable"*, it was somewhat Spartan and she would like one day to donate a comfortable armchair for breastfeeding. Although she had *"good emotional support"* from RF, RC4 really needed someone to care for her baby while she slept, a service not provided by RF. Ideally, RC4 would have liked *"an extra hand"* at home where her surroundings were familiar: *"When you're at home, you know where everything is"*. Nevertheless, had RF not had other guests to stay, RC4 might have stayed a little longer with her.

RC5 did not want to stay in hospital but was not ready to go home. Staying with RF contributed to her physical recovery and meant that she was less exhausted, able to focus on bonding with her baby, and could be more patient with her other children. She had debated with herself whether she needed to go to The Haven:

Should I come here now, you know? … The kids are at school, so, you know, I can maybe stay home….. But then, once I came, I just felt like how much more relaxed I was, and …I feel like I have much more energy for them. … When I was at home, I wasn't taking care of my needs properly… I wouldn't go and make myself breakfast and lunch. …(RC5)

RC5 said she could not have used the service if she had had to pay for it. She appreciated that RF *"is not on top of you"* because she is at work during the day. RF's absence at work during the day was not discussed by the other mothers, nor were any ramifications raised of being alone in her house.

Mothers' and health professionals' views on the benefits of a community-based model of residential care as a positive addition to existing health-based services

This research question sought views on a community model of care, both a theoretical generic model and The Haven service.

Women who had used The Haven

They tended to say that a community-based model of residential care could be beneficial, although they were not without reservations. RC1 thought it would be useful to stay in a hotel under professional supervision for a few days and emphasised that women should have a room to themselves rather than sharing with other women. A few women liked the idea of having single rooms with a communal room where they could meet and talk with other women (RC1, RC3, RC4). RC2 thought that women would benefit most from help in their own homes rather than going to residential care; she (and others) appeared not to equate The Haven with a community model. When asked about the local hospital's *"sleep school"* RC2 said that she would never go to a *"sleep school"* which she described as *"mean"* and *"a prison."* RC3 endorsed the idea of non-residential community support groups but also said that we *"need to clone RF"*. RC4 said that having women in a private home would be *"a little bit awkward"*; her use of RF's home was not discussed in this context. RC5 did not discuss a generic model of community care.

Women who had not used The Haven

Two said that they would prefer to have someone come into their own home to help, whether a live-in for a short time or visiting daily (NC1, NC5). The interviewer suggested to NC1 some of the benefits of The Haven, but NC1 insisted that she would not like to go to a doula's home. NC1 thought she might have benefited from some extra rest between hospital and home but advocated an early, brief stay at a

local hospital as her preferred model. NC2 said, in contrast, that she would have loved to stay in a doula's home as long as she was in her own familiar community, although being helped at home would be best.

Going into someone else's house is better than hospital, but still a little bit uncomfortable. ...(If it's) there in the community, I guess it would be a little bit better, because you're in an environment that is familiar to you. ... A centre like the centres that we visit for the babies to meet the maternal health nurse. Essentially that, but we stay there. It's a little bit smaller. It's a little bit more intimate. ... So there is a bit more of a connection to the community. And I think that, yeah, I think that would be ideal. (NC2)

What NC2 valued was not pampering but access to *"reliable, non-conflicting information."* NC3 appreciated RF's *"amazing"* care as a doula and would have considered going to her had she not had family assistance and *"incredible"* support from her *"religious Jewish community"*. She thought other women might be concerned about who would care for their husband and other children, but would find the company during night feeding helpful. Although NC4 and NC5 thought that some women might like a community service, they would not use it themselves. NC3 said, *"I like my bed"*.

Maybe I would like to go to a place where they can help me, but also, maybe, like, I have another three children. So maybe there's someone who can come to my house and help me, maybe prepare dinner, or just for a few hours. No, maybe the whole day… Maybe this person can be with [my baby] when I'm washing clothes. (NC5)

The Professionals

The professionals raised different concerns about a community-based domestic model of care. P1, for example, thought community care was inappropriate because of the potential for non-evidence based conflicting or unhelpful advice from non-credentialed caregivers, problems with insurance coverage, and the challenges of establishing responsibility if *"something goes wrong"*, a view echoed by P8. In contrast, P2 thought The Haven model could be useful in principle and was aware of several patients who had used the service. P2 valued it as an opportunity to focus on the mother-infant bond despite the problems of *"who is going to monitor and regulate"* the service. P2 identified support for the mother, often from families, as the key preventive or ameliorating factor in the postpartum period.

P3 was concerned about women with inadequate support at home and thought that a community residential model might work for *"low-risk*" women, although P3 favoured greater support in the woman's home. Having someone come in for three to six hours a day would be ideal. P4 thought that a community-based model, where women had their own rooms and could come to a communal room to meet with other women could help some new mothers. However, P4 also asserted that *"most people are really happy to be in their own environment"*. P7, too, said, *"sometimes it is better to just be home and sleep in your own environment,"* as long as there is family or community support, including providing meals and taking care of the baby while the mother sleeps. According to P7, *""there is no village for women now in our ... Western communities. We are luckier in this small community, in the Jewish community. We have better supports."*

P5 recommended that mothers should go home and *"see how you are"*, taking advantage of advice from the visiting nurse. If they need extra support, P5 thought a community residential model might be useful, as long as there was access to *"appropriate medical help"*. The service would also require *"a lactation consultant on call; a friendly paediatrician, ... a GP that's got an interest in infant health, maternal health; physical therapy, ... because you do see perineal dysfunction."* Along with professional support, the person in charge would need to have extensive experience in caring for infants. P5 also emphasised the need to honour and respect mothers.

P6 valued the supports already available, such as community programs for women who have experienced violence or homelessness, and home visits for other women. Where women lack family support, a longer hospital stay might be helpful, or a few days in a transitional hotel: non-medicalised but with medical and lactation support. The ideal would be to have someone come to help women in their own homes. P6 suggested that *"a homely residential sort of environment"* might serve as a *"preventive model"* against anxiety. A homely, community environment was also stressed by P7: *"it's not about being in a hotel room by yourself. ... It's more about being with other women who have just given birth, and the whole entire thing is just designed to take care of you"*. P7 thought that emphasis of care should be on the mother, not the baby.

However, P7 also said that there is stigma associated with mothers needing additional care after birth, and this narrative is what must be changed first: *"It's not that you weren't coping. It's that you deserve this. You should have a rest."* P10, who acknowledged that she had had limited experience with new mothers, thought it might be useful to have *"somewhere where resources could be at your fingertips, where you could be encouraged to ask for what you need. ... To be able to get answers."* However, she was unable to elaborate on what kind of service that might be in terms of location, staffing or funding.

P8 emphasised that:

"Home services" are best; in the absence of family support, mothers "are going to need education and resources, ... some of which could be videos or films or podcasts, some of it written and some of it actual support from people who have the skills and ability. ... In a digital world that could be delivered to them. ... In-the-home services would be much better."

P9 also emphasised the need for education, as well as *"in-home help"*. However, P9 was prepared to consider a residential service as long as it included round-the-clock professional care and opportunities to meet with other women in similar circumstances.

P8 argued that services would not include someone holding the baby at night while the mother sleeps, asserting, *"At the end of the day, all parents just have to get on with it."* P8 thought he might once have supported The Haven model:

"If you'd have asked me that 5 or 10 years ago, as a consultant paediatrician... I might say, 'Yeah, I think that sounds great.' You're asking somebody at a medical administration level. I think we live in a world of regulations and increasing difficulties in meetings all the requirements, and I think the idea of that sounds great. But ... how is it going to be a registered mental health facility? ... So I live in a world whereby regulations, unfortunately, cut across good ideas."

All of the professionals emphasised the need to support mothers through a variety of publicly-funded means in addition to whatever family and community support that was available. These could include telephone helplines, home visits from lactation consultants, and group sessions with midwives. P8 urged an increase in support from maternal child and family health nurses. Most also commented on the confusion engendered by differing, often conflicting, advice given in and out of hospital on such things as feeding and settling infants. P6 in particular recommended that mothers be told that babies

are *"unpredictable"* and not to set *"unrealistic expectations"* for themselves.

Synergies and differences between an Australian and similar models of care Internationally, and perceived benefits and challenges

There was limited discussion of international models of postnatal community care; some participants did not mention them at all. Of the women who had used The Haven, RC1 had experienced Kimperton care in Israel, as had her mother, and would like to see the model introduced in Australia. RC1 and RC2 both remarked that Kimperton care was not free. RC2 had not used it and said that families in Melbourne had fewer children than those in New York and Israel which meant that the Kimperton model was less necessary here. RC5 had also experienced and enjoyed after care in Israel; in South Africa she had a full-time nanny and a cleaner and did not require additional care.

They have them everywhere, ... those special places after kids are born. ..., I had two in Israel, and I did go there, and then I had another three here, in which I didn't have it, ... I wanted to have it again. ... The recovery is so different when you have this support. ... Here, you come home to a house full of kids... but still, you know, even your home, the noise, that your brain can't relax when you know that the pile of dishes or the pile of laundry is reaching the ceiling soon. (RC1)

Women who had not used The Haven referred to Korea (NC1), Greece (NC2), and Spain (NC2) as looking after new mothers well, without giving details. NC3 knew about the Kimperton facility for Jewish women in the USA.

Medical professionals referred to *"Asian cultures"* (P3) as looking after mothers for forty days, and P4 thought the ideal was *"the Chinese way of the mother looks after the baby, and everybody else looks after the mother"*. P5 made a similar point for *"traditional societies"* and also acknowledged the Kimperton facilities for *"orthodox Jewish women"* that P5 thought might be *"old-fashioned"* with babies in nurseries rather than with the mothers. Some of these facilities were philanthropically funded, which made them affordable. P7 lauded the *"massive businesses"* that make residential care available to Jewish communities in America: *"They're luxurious; ... it's like a massive hotel, beautifully catered food, baths, bars, massages ... But that is extremely expensive, and it's a bit of a luxury and a privilege to be able to go there. But how amazing would that be if everyone could go there?"*

Discussion

There was consensus that women who have recently given birth need support to recover physically, establish lactation, ameliorate exhaustion, build parenting confidence, and counter inadequate or conflicting information. Those who endorsed a model of community care preferred one where a woman was not isolated but could talk with other mothers to share experiences. Professionals, in particular, emphasised the need for a community facility to include expert professional care to ensure safety and evidence-based advice, overcome concerns about women's and infants' health, with attendant legal, quality of care, occupational health and safety, and financial ramifications. Rather than strong backing for a community facility there was encouragement for greater assistance to women in their own homes, with the nature of this assistance—cleaning, cooking, help with the baby, help with other children—to be identified by the woman receiving care.

In addition to questions of quality, safety and staff credentials, the economic aspects of any services are a serious consideration. Models of care that rely on volunteers are not sustainable or easily managed. A domestic residential model of early support has intrinsic appeal, but affordability, accessibility, availability, sustainability and scalability are not clear and have to be addressed. A fee for service model would constitute a barrier with two informants who used the service saying they would not have been able to afford it if they had to pay a fee, or providing ambulatory services and/or additional home help. Government and philanthropic funding to help meet the financial burden remain paramount so as to provide such services for all who sought them.

In Australia there are tertiary centre run mother-baby units for mothers who have severe mental health problems such as treatment for drug addiction, severe depression or postpartum psychosis. Australia also has unique residential early parenting services in both the private and public sectors. These provide structured residential psychoeducational programs for women with mild to moderate mental health problems including adjustment difficulties and whose babies are unsettled with persistent crying, resistance to soothing and frequent waking after short sleeps and are highly effective.[5] About 6% of women are admitted with their infants to one or other of these services annually.[6] However, apart from prescribed visits for development and health checks to a centre based maternal and child health nurse, there are no publicly provided support services for otherwise healthy women who have recently given birth.

These findings echo Winnicott, a paediatrician turned psychoanalyst who stated that *"while childbirth had many overwhelming positive aspects, women in the early postnatal period commonly feel 'drained' emotionally and fatigued from a lack of sleep and the ongoing demands of the new baby."*[7,8] There is an agreed unmet need, and a potential model of informal care that might reduce risk of future problems, but uncertainty about whether it meets safety and quality standards. These findings indicate that community-based, affordable models of care to provide support for women who have recently given birth, including the one considered in this study, warrant consideration alongside exploration of alternatives like home-visiting support and postpartum rehabilitation.

Strengths and limitations

The strengths of this study include that it enabled a diverse group of women who had recently given birth, primary and specialist health care providers and health service administrators to reflect on the unmet needs of women caring for infants in a particular setting and whether a voluntarily run local service might address them. Semi-structured interviews allow the interviewer to probe further, clarify responses, and follow up on emerging ideas. Participants can use their own words and contribute nuanced information that may not emerge from surveys with fixed response options. The conversational format can help participants feel more comfortable, which may encourage more reflective or candid responses,

We nevertheless acknowledge that this study was focused on a specific service in the Jewish community. The number of mothers and professionals interviewed were quite small and reflected the very time consuming methodology used – the interviews, transcripts, analysis etc. Most of the mothers were members of the Jewish community, which might have led to less diversity of views. However apart from some specific religious needs, their experiences are likely to reflect those in the community at large.

Conclusions

Many women who have recently given birth have unmet needs for practical and emotional support resulting from their short hospitalisations for confinement. They seek additional services whether utilising a residential model or an ambulatory program or being provided with additional home help. Safety issues together with the financial burdens were emphasised by the caregivers. While the immediate benefits to mother and infant have been noted, the long term implications of improved health and wellbeing of the mother and the infant arising from the added attention and care in the immediate postpartum period although likely, still needs confirmation by ongoing studies.

Acknowledgement

This research, initiated by The Haven Planning Committee, was spearheaded by the late Dr Raie Goodwach who prepared the question guides, finalised the application to the Monash University Human Research Ethics Committee, sought consent from the participants and subsequently interviewed them. Sadly, she became acutely unwell and was unable to analyse and report on her work before she died. Analysis was subsequently carried out by Dr Maggie Kirkman and Professor Jane Fisher who prepared a detailed report from which the co-authors drew this paper. Emeritus Professor Margaret Hay and Professor Samuel Menahem helped in conceiving and planning the study, reviewed the outcomes and helped as did Dr Kirkman and Professor Fisher in finalising the submission.

The magnanimous contribution of Mrs Raizel Fogel in conceiving and then providing the care so appreciated by those availing themselves of the complementary service she offers was recognised by her receiving The Caulfield Volunteer Award in 2022.

Footnote_

A formal body called "Haven for New Mothers and Babies" was established to extend RF's residential model into the wider community. The Board have taken note of the findings of this study and aim to provide additional ambulatory care to the residential model pioneered by RF, and to evaluate these services to contribute to the evidence base for postpartum care. This study throughout was independently carried out under the auspices and guidance of its senior author (JF).

Conflicts of interest

None to declare.

References

1. Withanage R, Hay M, Menahem S. Exploring a volunteer community residential care facility for new mothers. *Int J Pregn and Chi Birth*. 2020;6(4):86–91.
2. Smythe E, Payne D, Wilson S, et al. The dwelling space of postnatal care. *Women Birth*. 2013;26(2):110–113.
3. Tan A. After a traumatic birth and postpartum depression, this mum built the centre she wished she had – in Vietnam. CNA Lifestyle. 2026.
4. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol.* 2006;3(2):77–101.
5. Fisher J, Stanzel K, Nguyen H, et al. Impact of a private sector residential early parenting program on clinically significant postnatal depressive symptoms experienced by women: Audit of routinely collected data. *Acta Psychiatrica Scandinavica*. 2024;150(5):458–473.
6. Fisher J, Rowe H, Hammarberg, K. Admission of women, with their infants, for psychological and psychiatric causes in Victoria, Australia. *Aust. N. Z. J. Public Health*. 2011;35(2):146–150.
7. Winnicott DW. The theory of the parent–infant relationship. *Int J Psychoanal*. 1960;41:585–595.
8. Lesley B, Louise E, Frances R, et al. Becoming a mother – an analysis of women's experience of early motherhood. *J Adv Nurs.* 1997;25(4):719–728.