THULA SANA

A home-visiting programme for mothers with young infants

Facilitators Manual

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MANUAL CONTENTS

THULA SANA: A home-visiting programme for mothers with young infants

Overview:

Thula Sana is a home-visiting intervention aimed at promoting mothers' engagement in sensitive and responsive interactions with their infants. The intervention targets pregnant women and mothers of infants aged 0-2 years from low-resource environments.

Programme Delivery:

The programme is delivered to mothers through home visits. Trained community health workers visit mothers twice during pregnancy, then weekly for the first 8 weeks after the baby is born, then every two weeks for two months, followed by a monthly visit for the following two months. This results in a total of 16 visits to each mother over a six-month period.

Thula Sana Home Visiting Sessions: Timing			
Session 1	Antenatal Visit 1	**Session 9**	Postnatal Visit 7 (7 weeks)
Session 2	Antenatal Visit 2	**Session 10**	Postnatal Visit 8 (8 weeks)
Session 3	Postnatal Visit 1 (day 3)	**Session 11**	Postnatal Visit 9 (10 weeks)
Session 4	Postnatal Visit 2 (day 6-10)	**Session 12**	Postnatal Visit 10 (12 weeks)
Session 5	Postnatal Visit 3 (day 17-21)	**Session 13**	Postnatal Visit 11 (14 weeks)
Session 6	Postnatal Visit 4 (4 weeks)	**Session 14**	Postnatal Visit 12 (16 weeks / 4 months)
Session 7	Postnatal Visit 5 (5 weeks)	**Session 15**	Postnatal Visit 13 (20 weeks / 5 months)
Session 8	Postnatal Visit 6 (6 weeks)	**Session 16**	Postnatal Visit 14 (24 weeks / 6 months)

Facilitator's Role:

During home visits, the facilitator is there to listen, communicate with, and counsel mothers, in order to encourage sensitive and responsive interactions between the mothers and their infants.

FACILITATOR RESPONSIBILITIES	
Conduct home visits to facilitate a dialogue / conversation with the mother	***No visit should be missed. Each of the scheduled visits must be carried out as planned***
Prepare (through reading, discussions) for each home visit	***Do not carry the manual with you or prepare while at the pregnant woman's or mother's home***
Deliver messages and information during each visit as per guidelines	***Do not lecture (instruct) the pregnant women or the mothers***
Check if all information / messages have been delivered accurately before leaving the household at each visit	***Do not suggest incomplete or wrong messages***
Consult supervisor for guidance if you are not sure what information / messages you need to deliver before visiting the household	***Do not ignore questions (no matter how ridiculous they may sound) you have regarding any of the visits***
Use the counselling and communication skills learned during this training	***Do NOT only deliver information during the home visits***
Ask the mother and other members of the family (if they have been included in the discussions) about their concerns, and address these before you leave. If you do not know how to address these concerns consult with your supervisor during the visit (if urgent) or after the visit (if non-urgent).	***Do not give false or inaccurate information no matter how urgent the information may be needed***
Make sure you keep to any promises that you make	***Do NOT make promises you cannot deliver on***
Maintain confidentiality (as outlined above) and keep information about mothers in a safe, secure place	***At no time should information on pregnant women or mothers be shared or read by members of your family or friends***
Answer the mother and family's' programme-related questions where possible and pass on the unanswered questions to your supervisor	***Do NOT ignore any of the household's questions***

Facilitators should demonstrate the following skills during all sessions:

IMPORTANT SKILLS:	
Demonstrate empathy 	Empathy is one of the most important building blocks in relationships as it provides the foundation for rapport. It takes place when we listen to someone who has a need to talk and be understood by another. The listener shows a willingness to truly understand the thoughts, feelings and beliefs of the mother. When this is communicated to the mother, she will feel accepted and understood. This is incredibly powerful, especially when a person feels over-whelmed, helpless and alone in their pain. Hints on how to empathise: • You need to listen very carefully to what the mother is telling you. • You need to become aware of your own feelings and those around you. • Remember that the basis of all empathy is respect and genuineness.
Listen attentively 	Listening is not simply a matter of sitting and taking note of what the person is saying. It is an active exercise; it is an art, a skill and a discipline that requires an ability to be comfortable with silence, keep your own needs outside of the session, and to focus your attention on someone else with a spirit of humility. Keys to attentive listening: • Ask for clarification: Asking friendly questions when something is unclear allows you to get more information and shows your interest and concern. *"Please tell me more about that?" "Can you give me an example?"* Even a simple "mm…hmm" will encourage the speaker. Some people feel threatened by questions, so make your probing gentle and supportive. • Empathetic silence: We are often uncomfortable with silence, but it is important not to fill up emotional spaces with talking just to cover our awkwardness. If you are comfortable with silence it can give the mother the opportunity to reflect on what they have said and to continue. • Minimal prompts: Using expressions such as, *"Oh…", "I see…", "Mm mm…", "Really?", and "And then?"* can encourage the person to carry on talking as she gets the message that she is being heard. • *"Tell me more"* techniques: These are ways in which one encourages another person to tell us more about her problem, *"yes, tell me more.", "Would you like to talk about it?" "I would like to hear what happened next."* • Reflect content: This means telling the mother what you have understood by what they have said, *"So you are saying that baby is keeping you awake a lot at night"*. • Reflect feelings: Let the person know that you have heard the feelings behind the content. What is the person feeling but not saying? Try empathy and think to yourself *"If I were in that situation how would I be feeling?"* Watch for body language; posture, eye contact, facial expressions, as these often reveal underlying emotions. Then check out your guesses. "You seem very disappointed?"

Show support 	**Providing Support:** **DO'S** • Be warm and friendly with mothers and their families • Make sure that the physical setting is private, safe and comfortable • Actively listen to what is being said • Be aware of non-verbal communication (hers and yours) • Ask clarifying questions • Respond in a way that encourages the mother to talk more • Try to understand what mothers are saying and feeling • Reflect what you are hearing back to her **DON'TS** • simply tell her what to do • interrupt • answer calls from your cell phone unless it is urgent • look down upon mothers and have an attitude that says: "I know it all" • provide too much information at once • provide irrelevant information • talk all the time, without listening to her exact concerns • divert the conversation to yourself
Communicate effectively 	**Basic communication skills to create a caring environment** • Greeting her warmly • Explain why you are visiting today • Speak in a gentle tone of voice • Act respectful • Ask the woman if she has any questions • Answer simply • Thank her for the visit and say when you will return **<u>Difficult situations</u>** If the woman is shy: - Speak of general things to 'warm her up' - Encourage the woman to speak - Praise the woman, to give her confidence - Repeat the question If the woman is argumentative: - Sympathize with her complaints (if any) - Do not push if the woman is still not receptive If the woman is inquisitive: - Answer her questions simply - Explain that you will visit again so you can talk more then If the woman is hostile / unfriendly • Listen to her • Be friendly • Try and praise her • Explain that you are there to help • Do not push if the woman is still hostile

What should a typical Thula Sana visit look like?

STEP	TIPS
STEP 1: **Create a safe and comfortable space**	• Introduce yourself and address the mother by her name • Explain your role again • Explore and clarify expectations of the day's visit (content, length of session etc.) • Ensure confidentiality • Maintain supportive contact through your voice or touch but do not invade space without their permission – be respectful • Take your lead from the mother
STEP 2: **Develop a trusting relationship**	• Frame your session by explaining what you are planning to deal with in the session, how the session runs and how long it takes. Empower the mother by letting her know what to expect from you • Tune in/warm up to the person's experience • 'Walk in their shoes' – empathise. Show you care • Respond to the person with respect, care and dignity • Do not take over or be judgemental • Remember the mother's and baby's needs come first • Be reliable, always do what you say and be on time
STEP 3: **Listen**	• Encourage the mother to tell you how they are doing in any way that she feels comfortable • Listen carefully and ask for details where appropriate • Empathise with the mother • Use all your listening and responding skills • Check out what she does to cope, for example, sleep, drink alcohol or talking to friends • Find out if she feels supported by family, friends or the community
STEP 4: **Providing relevant information**	• Acknowledge the mother's difficulties and highlight that together you will work towards a solution • Discuss ways of coping that may be useful to the mother • When appropriate provide relevant information • Ask her if she has understood what you have told her • Ask her if she has any questions or would like more information
STEP 5: **Saying goodbye**	• Check if there are any other issues worrying the mother from this session • Arrange for a follow-up appointment • Discuss how she can mobilise support from friends, neighbours and spouse • Direct mother to medical, legal, religious or social support (when appropriate) • Bid the mother goodbye and wish her well

The Behavioural and Interactive Assessment of the Baby (BAIB) [1]

A major component of the Thula Sana programme is an "assessment" of the baby's individual and interpersonal capacities. This is not a formal assessment, but rather an activity that provides the facilitator with a structured way of observing and understanding each baby as an individual. By your involving the mother in this assessment you will be able to draw the mother into her relationship with her baby.

The assessment involves observing the baby's behavioural response to stimuli, as well as the presence of certain elicited reflex responses. **These are seen as the baby's way of communicating with his mother.** From these observations it is possible to see how the baby makes sense of his environment. In particular, it highlights the baby's social responsiveness.

One of the main goals of this assessment of infant capacities is to establish a **COLLABORATIVE** relationship with the mother (and, possibly, the father), using the baby's behaviour as the language of communication.

By your drawing the mother's attention to her baby's inbuilt capabilities and weaknesses, she will be able to see her baby's behaviour as meaningful which will enable her to meet baby's needs more appropriately. The increased awareness of her baby facilitates a more sensitive approach by the mother, which in turn serves to improve the quality of the mother-baby relationship. This partnership between you and the mother in parenting will enable the mother to achieve the best possible outcome for herself and her baby.

Potential benefits of enhancing the mother's awareness of her baby:

- Better management of baby's sleeping, feeding and crying, and prevent possible longer term problems from occurring

- Mother's awareness of the baby's inherent sociability will facilitate an enhanced sense of relationship with the baby, and the personal nature of baby's connection to his parents.

- By feeling in good relationship with the baby, the inevitable hurdles to be negotiated in caring for the baby are less likely to make the mother feel helpless, or oppressed and persecuted by the baby. Instead, a feeling of empathy or identification with the baby is fostered that results in sympathetic and sensitive personal care.

[1] This assessment is derived, in part, from the Brazelton Neonatal Behavioral Assessment Scale, *Clinics in Developmental Medicine*, No. 137, T.B. Brazelton and J.K.Nugent, 1995, and from The Social Baby, L.Murray & L.Andrews, 2000.

The Role of the Facilitator

In the lead-up to the BAIB, you need to set the scene to show that you are receptive to the mother's feelings and concerns about her baby, both real and imagined, voiced and unvoiced.

This sensitivity will enable you to pay attention to these concerns and those that may arise during the assessment. This sensitivity is achieved through adopting empathy, listening attentively, showing support and communicating effectively.

You need to give the mother a brief overview of the assessment. It is important to highlight the fact that most babies cry as a response to change in their environment; and that crying is part of the assessment as it will provide valuable information as to what, if anything, the baby does to console himself, and what kind and level, if any, of intervention is needed in order to console him.

Throughout the assessment you will be acting as a role-model for the mother, using your skills to facilitate the best possible response from the baby.

You will try to make the best possible sense of the baby's responses to his mother, drawing her attention to his strengths and difficulties. Both must be presented in a **positive** way: his sensitivities are presented as his way of demonstrating his need for a more sympathetic approach.

Administering the BAIB

WHEN:

The BAIB will be conducted at the following visits:

- **Session 4:** Postnatal Visit 2 (day 6-10) **= FULL ASSESSMENT**
- **Session 5:** Postnatal Visit 3 (day 17-21) = ANY ITEMS NOT COMPLETED DURING PREVIOUS SESSION
- **Session 7:** Postnatal Visit 5 (5 weeks) **= FULL ASSESSMENT**
- **Session 8:** Postnatal Visit 6 (6 weeks) = ITEMS 9 and 10 ONLY
- **Session 9:** Postnatal Visit 7 (7 weeks) = SOCIAL RESPONSIVENESS ITEMS ONLY
- **Session 10:** Postnatal Visit 8 (8 weeks) **= FULL ASSESSMENT**

WHERE & HOW:

Ideally, the BAIB should take place in a quiet, warm, semi-darkened room, and the baby should be asleep and midway between feeds.

During the assessment you will need to give a running commentary about each item of the baby's behavioural organisation and responses in relation to the baby's current developmental agenda. If, for example, you observe the baby bringing his hand to his mouth, you should interpret this to the mother as a high level of motor organisation in this baby, his way of regulating his own state.

In this process you will be demonstrating to the mother your own observation skills in the context of the baby's unfolding behaviour and drawing the mother into these discoveries. This collaborative setting provides a rich opportunity for you to develop a supportive relationship with the mother at a time when new mothers often feel anxious and vulnerable. It will help the mother to develop and refine her own observation skills, enabling her to detect the more subtle signs of stress, such as colour changes or gaze aversion, which are often difficult to see and interpret. These can be pointed out to the mother to help her regulate her responsiveness to her baby.

Your principal aim in carrying out the assessment is to focus on the baby's behaviour and direct the mother's interest to him. At the end of the assessment the mother is likely to be fully focused on her baby and to want to hold him. This is the ideal setting for you to discuss the baby's own style of behaviour, what this means in terms of the mother caring for him, and how these behavioural styles may develop.

General Notes on Infant Behavioural State

A core element of the BAIB is helping the mother to observe and understand the different infant states. During the course of the assessment you and the mother will observe the range of states available to the baby, and how he moves from one state to another. This is called state organisation, and how the baby moves through these stages is **unique to him**.

Six different states have been identified and are defined as follows:

State 1	Deep sleep with regular breathing, eyes closed, no spontaneous movement, no rapid eye movement (often called NREM sleep). Startles may appear.
State 2	Light sleep with eyes closed, irregular respiration, more modulated motor activity. Rapid eye movements are present (often called REM sleep).
State 3	Drowsy or semi-alert, eyes may be open or closed, activity levels are variable.
State 4	Alert with bright look, minimal motor activity.
State 5	Eyes open, considerable motor activity. Fussing may or may not be present.
State 6	Crying state.

Throughout the BAIB, you and the mother will observe the baby together, and you should point out which characteristics are prevalent in each distinct state and how the baby makes his transitions from one state to another.

By recognising that babies have different states the mother begins to recognise the pattern of her baby's life, and is then better able to understand and predict the baby's behaviour. The mother may be able to see, for example, that the infant usually starts to become very active and fusses (state 5) before sleeping. Similarly, she will begin to recognise that certain interventions are more appropriate in one state than in another (e.g., babies in a sleep state will not respond well to feeding, and the mother's attempt to feed will be neither beneficial nor rewarding for either of them).

COMPONENTS OF THE BAIB:

The Behavioural and Interactive Assessment of the Baby (BAIB) has ten components.

Summary of the BAIB's 10 Components

Initial observation period

Ability to shut out intrusive light and sound while asleep

Uncovering and undressing and placing in supine (on his/her back)

Rooting and sucking

Ventral suspension

Crawling

Defensive movements (cloth over face)

Cuddliness

Imitation and responsiveness

Social interactive package

1 **Initial Observation Period**	## Initial Observation Period Ideally the assessment should be started while the baby is asleep. You should then begin by describing the baby's behaviour, focusing on whether or not his eyes are open or shut, whether he is in REM or NREM sleep, his breathing pattern, any movements local or global, organised or spontaneous and whether he is crying or not. These observations may lead into a deeper discussion about the different types of sleep, and what is an appropriate and realistic expectation for this age. It should be explained to the mother that the length of sleep-wake cycles will change with age, and eventually a diurnal pattern will evolve (see section on Sleep - Postnatal Visit 2 (day 6-10), p33). ***What does this mean for infant care?*** Every baby will have his own sleep pattern, the differences in sleep patterns from one baby to the next can vary widely. It may be reassuring for some mothers to know that some babies need more sleep than others, and that whereas some babies will be able to maintain a sleep state overnight after a few months, others will take much longer. The important issue is to enable the mother to observe her own baby's cues, showing when he is ready to sleep (see sleep section).
2 **Ability to shut out stimulation when asleep**	## Ability to shut out stimulation when asleep Before the next two items are presented you need to describe what you are about to do and what you are looking out for in terms of responses from the baby. It is important that you point out to the mother that you are not carrying out a vision or hearing test, but, rather, an assessment of how the baby is able to protect himself from intrusive stimulation and how he responds to stress. Ideally you will present these two items to the baby whilst he is in state 1 or 2. However, if after presenting the first item for the first time the baby makes no response at all, you may need to uncover or gently rock the baby to try and rouse him out of a very deep sleep into a more receptive state. **1. Shutting out Light** You should shine a light across the baby's eyes at a distance of approximately 22 cm. The minimum response is eye tightening or furrowing of the brow. Other responses may include other facial expressions, small hand/finger or foot movements, changes in breathing pattern, or much more global movement such as a "startle". You should note if the movements are instant or delayed, increasing in amount or decreasing. After the first presentation of the light you should wait until all movement has stopped before presenting the light again. This item can be presented up to 10 times, but once a "no response" has been noted following previous responses, the light need only be presented twice more to confirm that the baby has successfully shut out the intrusive light stimulus. **2. Shutting out Sound** The rattle should be shaken at about 25-30 cm. distance from the baby's ear. The sound of the rattling should be sharp and abrasive: a single brisk flicking action should be used. The baby's responses should be noted in the same way as for the light: localised or global, instant or delayed, decreasing or increasing. This item may also be presented up to 10 times; but once a "no response" has been recorded following previous responses, it need only be presented twice more to confirm that it has been successfully shut out. If, during either of these two items, the baby moves into state 4 or above, this part of the assessment will have to be discontinued and, you can move onto the next item.

Additional Notes for Component 2 (ability to shut out stimulation while asleep):

The need for sleep in babies is greater than in adults. The baby's ability to shut out negative stimuli is therefore of vital importance to him. You and the mother will be able to observe the baby's responses to stimulation and whether or not he is able to shut out the negative stimuli. Babies have a capacity for early learning and some babies can store information about negative stimuli (such as noise), and then when it occurs again, they can shut it out. As the baby gets older this ability improves and he will be able to sleep for longer periods.

There are 4 strategies a baby can use to deal with unpleasant or inappropriate stimuli:

1. Actively withdrawing from it for example by creating physical distance by turning the head, arching, shrinking
2. Rejecting it by pushing it away with hands or feet while maintaining its position
3. Decreasing its power to disturb by maintaining its position but decreasing sensitivity to the stimulus - looking dull, yawning, or withdrawing into a sleep state
4. Signalling behaviour - fussing or crying which brings adults to him/her to help him/her to deal with the unpleasant stimulus

The ability to shut out (unpleasant or inappropriate) stimulation varies widely, and it can be influenced by perinatal variables such as maternal obstetric medication and the baby's nutritional status. Clearly, the extent to which a particular baby is successful and efficient at doing this has implications for care-giving.

The importance of these items for care-giving lie in two major areas:

- If the baby is able efficiently to shut out negative stimuli, this will show a robustness. This will mean that the baby will be able to sleep amidst the normal hustle and bustle of home life (e.g. vacuuming, TV., etc.). However, if the baby find it is more difficult to shut out negative stimuli, this will alert the mother to her baby's sensitivities. She will then be able to provide him with a more protected environment (e.g. a quieter or semi-dark environment). Babies who find it difficult to shut out stimuli on this part of the assessment may also be generally sensitive.

- The baby's capacity to shut out stimulation is a demonstration to the mother that he is actively doing something for himself (i.e. is an agent), in that he is able to regulate his own state. This may help to reduce the mother's anxiety and allow her to relax.

3

Uncovering, undressing and placing in supine (on his/her back)

Uncovering, undressing and placing in supine

You take the cover off the baby and then undress him carefully placing him in the supine position – on his back - with his head in mid-line. You then describe your observations, such as changes in state, alterations in colour, the baby's efforts to console himself (e.g. hand to mouth, focusing on an object).

What does this mean for infant care?

Undressing a baby is a very invasive activity, involving not only handling but also a possible drop in body temperature. This can lead some babies to feel very vulnerable. Others cope with this potentially stressful situation more easily. As well as assessing the baby's general vulnerability and sensitivity, this item also presents an opportunity for you to assess the baby's general tone by gauging the ease or resistance of the baby to being undressed and handled, and to observe whether the baby is hypertonic (flexed), hypotonic (floppy), or relaxed at rest.

As the baby gets older, he will be able to tolerate the more invasive activities and being left without his clothes on for longer. His tone and motor organisation will also improve.

By undressing the baby and lying him on his back the effects can readily be observed by you and the mother. As this is a procedure that the mother will be doing several times a day (i.e. in changing his nappy, bathing him etc.), it is a useful way of identifying babies who are particularly sensitive, and who therefore need a more sensitive approach to their care-giving. If this is the case then the mother might not fully undress him and/or bathe him daily to begin with, but gradually introduce him to nakedness over a period of time. Or if the mother finds that her baby flails his arms about during nappy changing and that this distresses him, she may find that gently inhibiting these movements by, for example, placing a sheet over him will help him to regulate his state and become less distressed (see section on Crying and Consolability - Postnatal Visit 2 (day 6-10), p37).

SWADDLING

For some babies, identified as sensitive in the item described above, swaddling maybe of value as a soothing procedure. Swaddling should be demonstrated to the mother.

She should be advised that it is only to be used in particular circumstances, when the baby is unable to settle without the security of being contained in this manner. The mother should be advised that, before swaddling, she should ensure that the baby is not over-wrapped for the room temperature, and that any excess clothing should, if necessary, be removed. She should be advised to wrap the baby in a cotton sheet ensuring that the baby is able to free his arms if he wants to do so.

During swaddling, it is very important that she is made aware that the baby's head should not covered. It is important to explain to the mother that, when lying a swaddled baby down, he should be placed on his back, or his side if he really cannot settle on his back. Stress that she must not use a bolster/blanket or any other prop to keep him in this position because it may interfere with his body temperature. If the baby is placed on his side, remind the mother to ensure his underarm is pulled out to prevent him from rolling onto his front.

4 **Rooting and sucking**	**Rooting and sucking** You gently stroke the corners of the baby's mouth, noting any head turning, mouth opening or tongue protrusions. Then, using your index finger (pad uppermost), you place your finger into the baby's mouth, noting the strength and rhythm of any sucking, and the burst-pause pattern. Both the rooting and sucking responses will be influenced by the mother's obstetric medication level, the state the baby is in, and whether or not he is hungry. ***What does this mean for infant care?*** Rooting is a primitive reflex that enables the baby to seek out his mother's breast. Following this item you will be able to help the mother to assess whether her baby is crying because he is hungry or for some other reason. This should help prevent the mother from feeling a failure or frustrated if she offers her crying baby a feed and he does not take it (with account taken of other possible factors, such as the baby's state, the mother's obstetric medication, and whether or not the baby is unwell). Although it is recognised that sucking is a reflex, its nature can and does change over time. In particular, the baby gets better at integrating its breathing and sucking and a burst-pause pattern develops. During the pause part of the pattern a baby will often be receptive to social interaction. This is especially noticeable if the baby is sucking for comfort as opposed to sucking because of hunger. As the burst-pause pattern becomes established, the opportunities for mother-infant social interaction increase and gradually become a part of the regular feeding activity. You will be able to discuss with the mother the benefits of this early opportunity to talk to her baby during this time. It is the ideal time to enjoy the close intimacy in the optimum position for doing so (approximately 25 cms between each others' faces). By drawing the mother's attention to the sucking and rooting reflexes she will be able to identify her own baby's patterns and recognise when he is either hungry or full. For some babies sucking is a way of regulating their state. Some will be able to put their hand to their mouth, whilst others will need help to achieve this. Others may need a dummy. The hand into mouth is generally more satisfying than a dummy because, on the whole, it is self-initiated. You can, where appropriate. encourage the mother to look for opportunities that will promote this activity if it is important to her baby, such as ensuring that his arms and hands are free to reach his mouth.
5 **Ventral suspension**	**Ventral suspension** You should suspend the baby's body face down over the palm of your hand. ***What does this mean for infant care?*** In the new-born baby his head, legs and hips will "hang" either side of your hand, giving a draped effect, although some babies will show signs of head control and hip extension. This is an opportunity for you to observe and discuss the quality of the baby's gross motor control and place it in the context of his developmental progress. By 6 weeks, normal developmental progress will produce an increase in motor maturity and muscle tone resulting in the baby being able to hold his head in line with, or higher than, his body, and with hips semi-extended. You can draw the mother's attention to her baby's ability or inability to control his head, and then show her how to make appropriate interventions (especially by giving head support to facilitate good eye contact and promote social interaction).

6 **Crawling**	## Crawling You gently lie the baby on his stomach, ensuring that his head is facing straight down in the mid-line position. You then describe to the mother what the baby is doing, how he lifts his head up from the surface and then turns his head to one side before he puts it down again. [Once his head is down again he may put his hand up to his mouth and start sucking]. Also, whilst he has been doing this, he will show his ability for spontaneous crawling movements using both his arms and legs. ***What does this mean for infant care?*** This ability to free his airway shows a capacity for survival. If hand to mouth activity occurs, this will probably enable the infant to quiet himself and become alert. Observation of the spontaneous crawling movements is another opportunity for the mother to see the beginning of a developmental process in her new baby. During the course of the first year the baby will progress from this obligatory response to greater voluntary head control, rolling from side to side and voluntary crawling. The crawling reflex, along with the defensive movement (see below), can be reassuring to mothers in that they show her that the baby has some inbuilt capacity to free his airways for himself. For some babies a short, closely observed, period placed in the prone position will facilitate a quiet alert state and promote the opportunity for social interaction.
7 **Defensive movements (cloth over face)**	## Defensive movements (cloth over face) With the baby placed on its back, ensuring that the baby's head is in the mid-line position, you gently place a cloth or piece of clothing across the baby's eyes, partially hiding the baby's nose. You then describe the infant's response in terms of how strongly he/she responds. Responses may vary from no response, to general quieting, rooting, head turning, neck stretching and directed/non-directed swipes to remove the cloth. ***What does this mean for infant care?*** This item assesses the infant's response to interference with visual and respiratory functioning. [From experience it has been noted that some babies who wear ill-fitting hats that cover their eyes show a greater tolerance for visual interference and make less strenuous efforts to remove the cloth]. As the baby matures his self-protective capabilities will improve and become more purposeful. **There are 4 strategies a baby can use to deal with unpleasant or inappropriate stimuli:** 1. Actively withdrawing from it for example by creating physical distance by turning the head, arching, shrinking 2. Rejecting it by pushing it away with hands or feet while maintaining its position 3. Decreasing its power to disturb by maintaining its position but decreasing sensitivity to the stimulus - looking dull, yawning, or withdrawing into a sleep state 4. Signalling behaviour - fussing or crying which brings adults to him/her to help him/her to deal with the unpleasant stimulus The defensive movement enables mothers to see how important visual stimulation is to her baby. This has particular implications for the baby who uses visual stimulation to calm himself and regulate state. For such babies, appropriate visual props such as mobiles or pictures can be discussed with the mother. It also offers evidence of the baby's own agency. Also, if the baby normally wears a hat for any reason, it may be worth discussing with the mother the need for the hat not to obscure her baby's vision because the baby will be missing out on important visual stimulation.

8 **Cuddliness**	## Cuddliness You cuddle the baby, first in the horizontal position, baby held along your forearm and against your chest; and then in the vertical position, resting his body against your body and shoulder, supporting him from behind. You then describe the baby's response to being cuddled in both positions. First you describe to the mother how the baby responds (e.g. nestling or moulding in, relaxing or resisting), and whether or not the baby likes to hold on to you. Then you describe how the baby responds to any facilitating movements you may have made, such as having to place your hands on the baby's head in the vertical cuddle to give more support. ***What does this mean for infant care?*** In describing the cuddliness or non-cuddliness of the baby (and whether or not there appears to be a preference for a horizontal or a vertical cuddle), the mother can be helped to recognise her own baby's temperament. If her baby is not receptive to being cuddled, this can be seen not as a reflection on the mother's handling or care-giving, but more a feature of her baby's individual style. However, it should be pointed out that a baby's sensitivity to such stimulation may change over the course of time and the mother will need to be alert to changes which might occur.
9 **Imitation and responsiveness**	## Imitation and responsiveness While the baby is in a quiet and alert state (not when feeding) attempt to engage the infant's gaze. The imitate whatever facial or mouth movements s/he makes. ***What does this mean for infant care?*** • The basis for the child's future emotional, social and intellectual growth lies in the early relationship which develops between the mother and her child. • The development and maintenance of this interaction depends largely on the mothers ability to not only encourage such interaction by responding to the infant's signals and other potential interactive behaviours and so develop a sensitivity to her infant's capacity for attention but also for his/her need for withdrawal from this attention either partly or fully, after a period of attention to her. Again it is important that the infant feels in control over the amount of stimulation he takes in during such an intense period of stimulation. The secret is to be responsive and sensitive and that having engaged with the infant, allow the infant to take the initiative and follow. Through imitation mothers enlarge and make the most of the smallest possible interactive behaviour. This provides a meaningful purposeful quality to the behaviour.

10

Social interaction package

Social interaction package

There are 4 separate components to this item:

1. Inanimate Auditory Stimulation (rattle unseen)
2. Inanimate Visual Auditory Stimulation (rattle-seen and heard)
3. Animate Visual Auditory Stimulation (face and voice seen and heard)
4. Animate Auditory Stimulation (voice alone unseen)

In order to bring out the best in the baby, these assessments are best attempted when the baby is in one of the alert states.

1. Inanimate auditory stimulation

You place the baby on its back on your lap, ensuring that his head is in the mid-line position. You gently shake the rattle 15-22cms from the baby's ear at right angles, out of his range of vision. The sound is presented as an attractive stimulus, a soft rhythmic sound, increasing in intensity until the baby responds. Once his level of responsiveness has been found, continue to present the stimulus at that level first on one side and then on the other. If the baby is observed to wince or startle, he is communicating that it is too loud, and the level needs to be reduced.

Together with the mother you should observe the baby's reaction to the stimulus, noting subtle responses such as changes in breathing or blinking or general stilling, through to alerting, shifting of eyes and head turning to find the source of the sound. Through this process, you will be able to discuss with the mother the need to provide appropriate auditory stimulation at a level that is acceptable to her baby.

2. Inanimate visual and auditory stimulation

Hold the rattle approximately 22cms above the baby. Starting with the baby's head in the mid-line position, engage the baby's attention with the rattle and move it slowly and smoothly across the baby's line of vision. You should move at the baby's pace: if he loses the stimulus, it will be necessary to re-engage his attention.

3. Animate visual and auditory stimulation

Starting with the baby's head in the mid-line position, use your face and voice to engage the baby's attention and then move in a slow horizontal arc across the baby's line of vision. It is important to remember that the baby's task is to track your face rather than find it. So, if the baby loses you, you should go back and help him find your face.

4. Animate auditory stimulation

Hold the baby securely with his head resting in the palm of one hand to allow for free movement, and his body supported by your other hand. He should be facing towards the ceiling, and should be held out approximately 22cms away from your body. Call the baby's name, ensuring that your face is out of his line of vision. Observe any reactions as already described for the Inanimate Auditory.

Additional Notes for the Social Intervention Package:

It is important when carrying out the social interactive package to take the following into consideration:

- Your clothing should be plain and dark so as not to over-stimulate the baby. Perfume should be at a minimum.
- You should not talk to the baby when administering items that don't involve talking
- The room lighting should be dim / muted and you should be aware of possible light reflections that may interfere with the baby's ability to follow a stimulus.
- These are not hearing or vision tests as such; rather, they show the importance of visual and auditory stimulation. They are ideal opportunities to draw the mother into the possibilities of social interaction.
- Babies can see at optimal distances approximately 22cms (or arm's length). This should be pointed out to the mother so that she can position herself appropriately.

What does this mean for infant care?

Many parents do not realise that newborn babies are able to see and hear quite well. As a consequence they do not imagine that their baby will be interested in their face or voice, or in looking and listening to things around them.

The demonstration of these abilities helps to enhance the mother's sense of the baby as an individual, with his own interests and capacities. In particular, the baby's social responsiveness can be a dramatic revelation to the parents, and is powerful evidence of the baby as a person, with whom they can have a personal relationship from the start.

The baby's rapidly developing preference for the particular characteristics of the mother [i.e. her voice, smell, face) can be even more reinforcing, giving her a sense of a very special relationship with her baby.

Key recommendations for conducting the BAIB:

- The main objective of the BAIB assessment is to think together with the mother about the baby as a person.

- You will have to judge whether the mother is accepting of your undressing and assessing the baby before the umbilical cord has dropped off. Some mothers have strong feelings about this and you might have to wait until the cord is off before going ahead with this assessment.

- The assessment should be administered in a way that actively, and in a supportive manner, involves the mother (and other caregivers, if they are present).

- It is important to be aware that **your interactions with the baby during the assessment will be a model for the mother.** You therefore need to be especially sensitive to cues from the baby. Very importantly, you should demonstrate a pace of talking that is not so fast that it cuts across the baby's initiatives, nor so slow that you lose the baby's attention.

- You should give a careful explanation of what the various components of the assessment reveal about the baby.

- You should point out to the mother that a particularly effective way of entraining baby in face-to-face engagement is to monitor the baby's own expressions and gestures and then respond, either through imitation or affirming the baby's initiative. This serves to give the baby immediate feedback about his/her own behaviour.

- You should be alert for any opportunities to facilitate sensitive communication between the mother and her baby, pointing out to the mother, her baby's responses to her.

- Such sensitivity to the baby, and the early active involvement of the baby in this two-way process of communication, in which his attention is maintained on a focus for prolonged periods, has been found to be highly predictive of the baby's later cognitive development.

- With regard to social interaction, remember to inform, and possibly show the mother that, within the first five days, her baby will turn towards her smell rather than another woman's smell. Similarly, he/she will quickly come to prefer the sound of her voice to that of any other person. He/she will also look more to her face than to the face of another woman.

- These behaviours are probably biologically programmed to help the mother feel that her baby is connecting with her and to foster or encourage a sense of a special relationship between them. This, of course, is just what the baby needs for optimum (best) psychological development.

- Also with regard to social interaction, remember to inform the mother that within the first few weeks (usually by around four to six weeks) babies show an intense interest in becoming engaged in prolonged (drawn out) interpersonal communication.

- If the mother gives the baby good head support and places her face at the optimal distance for the baby's vision (about 22cms), the baby will watch intently and, if the mother is responsive, can be drawn into a "conversation".

  Babies of this age will use their mouth and tongue actively, with wide, open, shaping, or protrusions of the tongue over or into the lips (so-called 'pre-speech').

  If the mother can be helped to see that this behaviour is not random, but a purposeful effort at communication, they can join in with the baby and together experience a two-way dialogue (referred to as 'proto conversations'). This is typically intensely satisfying for mothers, giving them the feeling that they are really in contact with their baby.

- You should give a running commentary to the baby of what is happening between you and him/her. Watch the baby's response to your commentary. For example, you might say to the baby "You really like talking these days" and then watch the response. This will help the mother to see which strategies elicit and sustain the baby's engagement. Once you have demonstrated this, explain to the mother what you and she have just learned about the baby, and how she could implement this.

  If you were insensitive and caused the baby to be avoidant, draw the mother's attention to it and explain to her what has just happened. For example, you might say "Did you just notice that? When I laughed suddenly he turned away from me. I think I overloaded him and came in too forcefully".

- At this stage, do not point out weaknesses such as the baby being low in tone and floppy, or some delay in the baby's response to situations. Keep your concerns in mind and monitor development with time. If you continue to feel concerned about an aspect of the baby's development it is likely that the mother has noticed it too. Affirm her observation and if you are sufficiently concerned and judge it to be necessary, refer her to the appropriate service. If you are concerned, but the mother is not either aware or concerned, bring your concerns gently to her attention and then refer.

- Once you have completed the assessment, you should give a review of how any difficulties which emerged in the assessment might be displayed during ordinary family care giving (e.g. when changing a nappy, undressing for a bath, putting the baby down to sleep). Also help the mother; father or potential caregiver who is present, think about managing these difficulties.

Helping mothers with engagement

There are four groups of mothers who need special help engaging with their babies:

Mothers who are severely depressed, emotionally flat and unresponsive	Some mothers, especially those who are severely depressed, are emotionally flat and unresponsive. Their babies will typically try to draw them into engagement, fail, and then withdraw. These mothers need to be helped to engage with their babies. A number of strategies can be used. First, the mother will need to be encouraged to talk to and play with her baby. Second, the assessment must be used to draw the mother's attention to her baby's individual characteristics and social capacities. It is especially important that you highlight instances of the mother behaving sensitively towards her baby, as well as instances of the baby responding to the mother. Finally, 'modelling' (that is, your demonstrating sensitive engagement) should be used to give the mother an idea of what sort of adult behaviour her baby finds engaging.
Mothers who overload their babies and are not sensitive	Another form of difficulty is where a mother overloads her baby by a constant stream of talk, without any sensitivity to the baby's own perspective. Since the baby is overwhelmed by the bombardment of stimulation, to protect himself, he may withdraw or become distressed and, consequently, will not engage properly. These mothers can be helped by slowing the mother down. They should be advised that the baby is having difficulty keeping up with them; and that it would be useful to see how the baby responds to the mother's remaining quiet and only responding to an initiative of the baby. By encouraging the mother to imitate the baby's communicative gestures and commenting upon them, she will be drawn into a meaningful engagement with her baby.
Mothers of babies whose motor control is rather poor	A mother who has a baby who has poor motor control (is either, jerky, tremulous (unsteady or shaky), tense or flat and sluggish) need help to achieve satisfying face-to-face engagements. For example, the latter group of babies may need additional head support to help them keep eye-to-eye contact. Those who are jerky and tense may find it distressing to be in a situation that babies with better motor control find optimal for social contacts (such as lying on his/her back during a nappy change). These babies are also likely to benefit from a supportive holding environment in order to be able to be fully interpersonally engaged. The assessment can inform you about the characteristics of the individual infant and the most effective strategies for facilitating a good state; and this information should be used to promote the best possible experience of face-to-face engagement for mother and baby.

Mothers who have babies who are irritable and sensitive	Mothers of babies who are irritable / sensitive, and who therefore have difficulty in regulating their state in relation to environmental stimulation, need particular help. These babies tend to startle at slight events, becoming rapidly disorganized and finding it hard to return to a stable calm state. In order to achieve and sustain such a baby's positive involvement in face-to-face interactions, the mother should be made particularly aware of the role her responses can play in helping to support the regulation of the baby's state. Stimulation that is pitched strongly, which may not disturb other babies, will in the case of one who is sensitive, be likely to contribute to the baby's state becoming disorganized. Mothers of such babies should also be made aware that it will be helpful to pay attention to the context of their interactions. Thus, laying the baby in on his/her back undressed may mean that the baby's spontaneous gross movements are more likely to destabilise a state of calm alert. Providing a more physically supportive environment, where the baby is held, for example, on her lap, may help the baby feel contained.

SESSION 1	
Timing:	Antenatal Visit 1
Overview:	The main purpose of the first antenatal visit is to start to build a trusting relationship with the mother so that she feels that **you are absolutely on her side**, **understand her point of view, and are supportive of her**. For that reason, try to arrange time alone with the mother during this visit. This might require some negotiating, as the mother probably did not know when you would be visiting her for the first time. It is important to be accepting of the mother, whatever you may feel about her or her circumstances. **Make it very clear that you are not there as an authority figure who checks up on mothers and evaluates them.** **NOTE:** *You need to adopt a counselling attitude of listening and reflecting her feelings. Stay with the mother and follow her lead throughout the visit and only once you feel you have established a trusting relationship do you begin, gradually and with sensitivity, to introduce your own agenda for the session. This applies to all future visits*
Agenda:	1. Introduction to the Intervention 2. Structure of the Visits 3. Time and Setting of the Visits 4. Confidentiality 5. Current Pregnancy 6. Arrangements for Next Visit

Activities:

1. Introduction to the Intervention

Introduce yourself to the mother and explain who you are in relation to the programme.

Tell her a little about yourself. (For example, that you are a mother, how many children you have and their ages, that you have a special interest in the support of new parents and their infants and that you understand that adjustment to parenthood is not always easy. You should say that you live in the community, but it is best, at this stage, not to give out your address.)

Explain that you are visiting pregnant women in the community at their homes antenatally and for the first 6 months after the birth of the baby. Explain how you came to know about her.

Explain that **your role will be to support her and that your focus will be on her and her experience with her baby. You will be helping her to learn about her baby**. For example you will be demonstrating her baby's individual qualities and interactive capacities which enable her baby to communicate with her and the rest of the outside world, to make sure his/her needs are met as they should be.

Explain that the programme is designed to help a mother have the best possible experience with her baby.

Explain that parenting is challenging for most parents, but that there are various factors that make it even more difficult for a mother to form an attachment to her baby ("bond" with her baby) and care for her baby. These include:

- Her pregnancy is unwanted or unplanned and she may have considered having an abortion.
- She has had stressful events in her life in the past year, for example, retrenchment, loss of home, loss of someone close.
- She has experienced a lack of emotional and financial support from her partner.
- She has been involved in incidents of domestic violence.
- She has experienced abuse in the past, for example, physical, emotional, sexual, rape.
- She has experienced a lack of support and practical help from family and friends.
- She has a poor, unsupportive relationship with her own mother.
- She experienced a miscarriage, stillbirth or the death of a child.
- She has had a serious depressive episode in the past.
- She is a teenage mother.
- She is a single-parent.

Suggest to the mother that perhaps one or some of these might be relevant to her. (She may start to open up to you or she may just nod in agreement or she may just stare back at you. Do not put her under pressure to open up.) Explain that when a mother has had any of these experiences, she needs a lot of support and our home visits can provide her with some support.

2. Structure of the Visits

You should explain what your involvement with her over the following months will be. This includes:

- There will be 2 **visits before the birth** (including this one)
- Each visit will last **an hour**
- **Fourteen further visits will follow postnatally** until her infant is 6 months of age. For the first two months the visits will be weekly, then for the next two months the visits will be every second week, and for the last 2 months the visits will be monthly.

3. Time and Setting of the Visits

Try to **set up a time** in the week when it would best suit both you and the mother to visit.

Arrange with the mother that when you visit, you and she will have private space where you would both feel free to talk without being interrupted by the radio or family, friends or neighbours. **This is very important.**

4. Confidentiality

It is very important that you explain to the mother how you will be working within a team, under supervision, and that **anything discussed with her will be kept confidential within the team.**

5. Current Pregnancy (discussion and input)

Ask the mother to tell you about her pregnancy:
Explore how she has been feeling physically and emotionally and whether she has experienced any problems in this time that are of concern to her.

Explore whether this pregnancy has been planned and the feelings related to this:
The very young mothers are unlikely to admit that they planned their pregnancy. Where mothers still feel unsure about the pregnancy, just allow them to speak about it. Don't try to reassure or convince them either way. It is their feelings we are concerned with.

If the baby, planned or unplanned, is now much wanted:
If the mother is an adolescent herself she might be dealing with very angry and disappointed parents. She may feel as though she is not allowed or can't be seen to show interest in her pregnancy, and might value an opportunity to talk about and validate her own feelings of disappointment, guilt, anticipation and excitement.

Some questions you could ask the mother:

- Does she have particular thoughts and feelings about her baby?
- Does she have any impressions about the baby so far (e.g. Is the fetus active? Does he or she react to particular external events or the mood of the mother? Can the mother sense some kind of routine in this activity? etc.).
- Does she (or anyone else) have a preference about the sex of the baby?
- Explore any concerns or fears that the mother may express. (e.g. particular fears in relation to whether the baby will survive, might be imperfect/handicapped, have positive or negative personality characteristic, etc….?)

Explore whether the mother has experienced any previous pregnancies, births, miscarriages, abortions, stillbirths or deaths of children or any other close family members.

Encourage the mother to talk and express her feelings about such experiences, as she will be close to these feelings in this pregnancy.

6. Arrangements for Next Visit

- Arrangements must be made for the next visit.
- The mother should be asked if she would like you to meet her partner (or any other important figure in her life who might be involved with the care of the baby).
- It is vital to provide private time for the mother to speak about issues she would **not** address in front of other family members, including her partner. But we also want to support the relationship between the baby and his/her father, as well as the relationship between the mother and other people who are part of her support structure.
- Make an arrangement with the mother to get a message to you should the baby arrive sooner than expected. Many mothers are unclear about their dates. You might want to give the mother a phone number where someone could call to let you know.

SESSION 2

Timing:	Antenatal Visit 2
Agenda:	1. Tuning In 2. Mother's Support Structures (discussion) 3. Labour and Birth (discussion) 4. Employment (discussion) 5. Mother's Partner / Baby's Father (discussion) 6. Arrangements for Next Visit

Activities:

1. Tuning In

On this visit you may meet the woman's partner and / or other family members.

- Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
- Be aware that sometimes a mother who has been very open with you during the first session, might be much quieter during this session, perhaps fearing that she has revealed too much about herself, too soon.
- When you feel that the mother has had sufficient time to express her **concerns,** gradually and with sensitivity, introduce your own agenda for the session.

2. Mother's Support Structures (discussion)

The fact that the visit is being conducted in the home allows you to enquire more easily about the housing situation and the household, including the availability of support. Try to cover the following questions:

- Whether she and the father of her baby are still together and if so: What his feelings are about this pregnancy. Does she feel cared for and supported emotionally and financially by him?
- Is her own mother present? How did she respond to the pregnancy? Is she supportive?
- Is her mother-in-law present? Is she supportive? What are her feelings about this pregnancy?
- Does mother have friends? Are they supportive?

3. Labour and Birth (discussion)

This visit will focus to a large extent on the mother's feelings about the birth and on how she will manage, and the mother's experience of previous pregnancies and births.

4. Employment (discussion)

Try to find out about work issues. For example, are there pressures to go back to work? Have arrangements been thought about?

If the mother is unemployed and she has no other financial support, ask about her **plans to support herself** once her baby is born.

5. Mother's Partner / Baby's Father (discussion)

If the partner is seen, a number of points should be kept in mind.

The main aim should be to encourage a mutually supportive relationship between the two partners. If the couple are in harmony, you should reinforce the partner's support and emphasise the value of his contribution for both the mother and the child.

If the partner communicates his own vulnerability and anxiety, this can also be used to strengthen the link between the couple, in that it can be noted that this is a very big emotional event for both of them.

The father may find it useful to have you acknowledge his feeling that everyone is focusing on the mother, but that he too may need attention. Thus, you should convey the feeling that both partners receive consideration and that diverse points of view can be heard, despite the primary focus being on the mother at this stage.

You should be aware of potential competition between the woman and her partner and the possibility that one or both of them may wish to create a situation where each individual is concerned to have you see them as the "good" partner, and the other as the "bad" one.

In such situations, it will be important to find a way of supporting both partners, reflecting back the perspective of each, but doing so in a way that does not ally you with one individual.

It is especially important that the mother's feeling that you understand and sympathise with her is preserved.

6. Arrangements for Next Visit

- Arrangements must be made for the next visit.
- Make an arrangement again with the mother to get a message to you should the baby arrive sooner than expected.

SESSION 3

Timing:	Postnatal Visit 1 (day 3)
Overview:	This visit, to be held as near as possible to the third day after the birth, will focus to a large extent on the mothers' detailed account of the birth and any joys and disappointments should be shared.
Agenda:	1. Tuning In 2. The Birth (discussion) 3. The Blues (discussion) 4. Concerns for the Baby (discussion) 5. Infant Social Responsiveness (note and comment) 6. Infant Behaviour (note and comment) 7. Wider Concerns (note and comment) 8. Arrangements for Next Visit

Activities:

1. Tuning In

- Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.

- When you feel that the mother has had sufficient time to express all her **concerns,** gradually and with sensitivity, introduce the other issues on your own agenda for the session.

2. The Birth (discussion)

Invite the mother to tell you her story of her experience of labour and birth in her own words. **Listen and reflect** on any concerns that the mother may raise.

Once she has told her story gently explore some of the areas she might not have covered. Encourage her to talk about:

- How she felt she was cared for.
- How she felt she managed the process of labour and birth.
- Did she want and was she allowed a birth attendant to accompany her.
- What were her feelings and thoughts as she saw her baby for the first time.
- What would have improved the experience for her.

3. The Blues (discussion)

You should enquire whether the mother has found she feels fragile and weepy, (has she had "the blues")? ***If so, be as supportive as possible and*** focus on any anger or sadness she may be feeling.

You should point out that these feelings are common, experienced by nearly all women, and that they will usually quickly settle down.

It should be acknowledged that having the baby provokes strong feelings; and any particular issues that came up to the surface should be aired.

If the blues continues for more than a few days, be aware that the mother may be postnatally depressed.

4. Concerns for the Baby (discussion)

The mother may have had anxieties and concerns about the baby in pregnancy. These should have been shared with you in the antenatal sessions.

The fact of the baby's presence gives an opportunity to return to these concerns and, in particular, to focus on relevant aspects of the infant's behaviour and functioning.

For example, the mother may have concerns about the baby's being damaged by the birth. Listen carefully to the mother and if you are equally concerned about an aspect of the infant identified by the mother, refer her back to the MOU for the problem to be assessed.

5. Infant Social Responsiveness (note and comment)

The full Behavioural and Interactive Assessment of the Baby will not be done until postnatal session 2 at 6-10 days. However, if the infant's behaviour gives any opportunity to comment on the infant's responsiveness to, say, the mother's voice, face or smell, you should exploit this by specifically pointing it out.

6. Infant Behaviour (note and comment)

You could use the opportunity to talk about the infant's behavioural state.

If you suspect that this may be an irritable/sensitive infant, it may be appropriate for you to say a little about individual differences in babies, and to introduce the idea that some infants are more sensitive than others, and that these babies need more support to help them regulate their state.

The aim should be to prevent any belief that, if the infant shows behaviour which the mother finds problematic, this is somehow the mother's fault. The mother might highlight aspects of the baby's behaviour which concern her. For example, a mother might be anxious that her baby does not sleep at night.

These concerns need to be discussed and placed in the context of normal infant capacities and development.

7. Wider Concerns (note and comment)

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available.

Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

8. Arrangements for Next Visit

The mother should be reminded that, at the next visit, you will be carrying out the Behavioural and Interactive Assessment of the Baby.

You should discuss with her whether her partner, or older children, or any other important figure in her life who might be involved with the care of the baby, could be present

SESSION 4

Timing:	Postnatal Visit 2 (day 6-10)
Overview:	The main agenda of this visit will be you and the mother (and father and the potential caregiver, if they are present) **thinking together about the baby as a person.**
Agenda:	1. Tuning in to the mother 2. The Behavioural and Interactive Assessment of the Baby (BAIB) 3. Sleeping (discussion) 4. Crying and Consolability (discussion) 5. Wider Concerns (note and comment) 6. Arrangements for Next Visit

Activities:

1. Tuning in to the mother

- Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
- When you feel that the mother has had sufficient time to express all her **concerns,** gradually and with sensitivity, introduce the other issues on your own agenda for the session.

At all times be aware and ready to recognize, point out and praise any positive, sensitive, responsive, loving, attuned, observant, emotionally expressive communication and interaction between the mother/caregiver and the child.

2. The Behavioural and Interactive Assessment of the Baby (BAIB)

Perform the full BAIB, i.e. all 10 components (refer to pages 8-23 of the manual)

3. Sleeping (discussion)

New parents often have two main concerns about their baby's sleep:

- They want to help their baby develop a clear distinction between night and day with prolonged sleep during the night.
- They will want to establish procedures for settling their baby off to sleep in a manner that is peaceful for the baby and that does not place enormous demands on them (by, for example, spending prolonged periods rocking a pram, or walking up and down with the baby in their arms).

The way in which you can help the mother is:

- Listening
- Providing information about sleeping behaviour in young babies
- Helping the mother understand her baby's behaviour patterns and rhythms and facilitating baby's transition to sleep
- Encouraging the mother to read her baby's sleep cues for moving to a sleep state
- Helping the mother devise interventions that are based on her baby's unique behaviour patterns and rhythms, to facilitate baby's transition to sleep

Listening

- Listen to her, allowing her share her concerns and challenges regarding her baby's sleeping. Try to understand the expectations the mother has in terms of sleep, both for herself and the baby.
- Be aware that she may or may not be realistic about what she expects from her baby. You should bear this in mind when thinking through strategies with the mother.

Providing information about sleeping behaviour in young babies

- During the first few days after birth babies typically spend considerable amounts of time in an awake, alert state, more time in fact than they will do for the next three weeks. These periods of alertness, cycling with sleep states, give the parents frequent opportunities to engage in direct personal contact with the baby, and to observe how the baby's state and behaviour change in relation to the environment. (it provides an opportunity for them to get to know their baby).

- In the beginning the sleep cycle of the baby and that of his parents are quite disparate or dissimilar. (e.g. the baby can be wide awake during the night, a time during which his parents usually are asleep).

- Gradually, their sleep cycles become synchronised (happen more or less at the same time) through the parent responding in a way that helps the baby to make the transition to sleep. Also, quite naturally, through the course of ordinary life, exchanges take place that help the baby adapt to his parents rhythms and day-night cycles. For example, having the baby sleep in a crib next to his parent's bed (or in his parent's bed) gives him and his parents repeated opportunities through the night to sense each other's rhythms through changes in breathing and state.

- There is some evidence that the first ten days may be an optimal time for establishing the initial co-ordination between the baby and the caretaking environment. Babies who have had care that is unresponsive in the first ten days are more difficult to manage in the subsequent two weeks than babies whose care has been responsive from the start.

- All babies wake frequently during the night. Most babies wake every 45 to 90 minutes throughout the night. Some wake up into a very light sleep or drowsy state but do not wake fully, and if they do wake up, they are able to go back to sleep on their own. Others, however, wake up, but are unable to make the transition back to sleep on their own and need external support, such as being rocked.

Helping the mother understand her baby's behaviour patterns and rhythms and facilitating baby's transition to sleep

- Each baby comes with his own unique rhythms of activity and quiescence (calm) and manner of moving between the six different infant behavioural states.

- With regard to particular advice, the best approach to achieving both the aims of settling to sleep and establishing a day-night cycle is founded upon a close observation of the unique behaviour patterns of each baby, and in particular an understanding of the individual baby's capacity to regulate his state, including how the baby uses his environment (personal or physical).

- The Behavioural and Interactive Assessment of the Baby will give you and the mother the opportunity to observe how smoothly the baby is able to shift from each of these states to the other, and how much, and what kind of environmental support the baby may need.

- Helping the mother to see the distinct states the baby experiences and what her baby needs to regulate his state will help her manage her baby's sleep in a way sympathetic to his own nature. This is to everybody's benefit because the *research evidence shows that where infant care fits in with a baby's own rhythms and is responsive to that baby's behaviour, babies are generally less distressed, and day -night differences in sleep patterns are established earlier than in those whose care is managed less responsively.

- Some babies have the capacity to move smoothly from one state to the next without a great deal of support. Others find transitions from awake to sleep states hard to manage themselves and need much more direct help.

Encouraging the mother to read her baby's sleep cues for moving to a sleep state

- Ideally, parents should become aware, from observations of the baby over the first few days, of the very first signs that their baby is becoming tired. These might be, for example, the baby's becoming avoidant or unavailable, moving to state 3 or becoming drowsy; or it could be shown in fussy or irritable behaviour.

- Again, based on observation of the individual baby, it may then be possible for the parents actively to arrange the environment to support the baby's transition to a sleep state as soon as the baby shows a sign that he is tiring.

- The effectiveness of a particular intervention is maximal when it occurs at a point where the baby is shifting from one phase in his rhythm to the next. For a particular intervention to become a cue for the baby to use in the future to help him make a transition to sleep, it should be used repeatedly by the parent at a particular phase in the baby's state cycle (For example, when the mother observes that her baby is tired she then lays him in his cot. She has learnt that he falls asleep easier when the radio is playing softly in the background. She lays him in his cot and puts the radio on softly when she notices that he is tired. This then becomes the baby's cues for sleep).

Helping the mother devise interventions that are based on her baby's unique behaviour patterns and rhythms, to facilitate baby's transition to sleep

Babies vary widely in what will help them make the shift to sleep state. A range of strategies is listed below, from those for babies who find it relatively easy to settle to those for babies who experience real problems.

In highlighting these strategies, consideration has been given to the fact that most parents will want to find a method of settling their infant that will not involve their having to be directly physically involved with the infant until he is asleep (as, for example, in patting the baby on his back, or rocking or feeding him to sleep).

- **Visual stimulus**

Some babies may need relatively little direct support and may be calmed by, say, engaging visually with the environment. If the mother has noticed this she may subsequently, as soon as she notices the first sign that the baby is getting tired, try putting her baby in his crib under a mobile with distinct visual contrasts and edges (placed 22cms above his head if on his back), or arranging similar patterns on the inside of the crib if placed on his side.

- **Auditory stimulus (e.g. lullabies)**

Another, similarly easily settled baby, may be able to use an auditory stimulus, a tape of lullabies for example, or the noise of a vacuum cleaner (!) to make the transition to a sleep state.

- **Active stimulation (e.g. touch, sucking)**

Other babies prefer more active stimulation through touch to help them go to sleep, perhaps sucking on something. It is easy for mothers of such babies, and particularly those who are breastfeeding, to misread these babies' cues and imagine that the baby is actually hungry. The mother in this situation may well offer the breast; and, indeed, the baby might suck, become less distressed, and fall asleep. The potential problem with establishing this pattern is that the baby will become adjusted to it, and might subsequently always need to suckle on the breast in order to be able to move to a sleep state.

Some families may not find this problematic, but mothers should be aware that this might not be a pattern she would like to establish. In such cases it is advisable to help the mother check first whether the baby is genuinely hungry. This can be done by seeing if the baby will root and suck strongly on a finger, and by noting the quality of the cry. If, of course, the baby is genuinely hungry he should be fed. However, it is possible that such a baby's behaviour does not specifically indicate hunger so much as a need for oral comfort.

Some babies who find sucking helpful are comforted by sucking on their own fist. Some might be able to achieve this by themselves. Others might only be able to find their fist if they are wrapped so that their fist is in position near their mouth. If the baby cannot achieve this kind of self-control, and sucking seems to be an important way in which this particular baby regulates his state and calms himself to sleep, then the mother might wish to consider using a dummy for this purpose.

- **Direct physical support (e.g. swaddling)**

Other babies may require more direct physical support to make the transition to sleep. Such babies may have rather poor motor control, and startle themselves easily out of a drowsy state into an alert one. In these cases, firm swaddling in a thin cotton sheet may be helpful to contain the baby's movements, and generally calm and soothe them. Some babies might require substantial ventral contact or physical support. It is obviously important if advising on swaddling to explain the issues of overheating.

- **Intensive support (e.g. rocking whilst walking around)**

In spite of trying out the strategies outlined above, some babies who become rapidly very disorganised and distressed when needing to sleep may need even more intensive support to become calm and sleep. These babies are usually highly sensitive to slight environmental changes and place great demands on parents.

Parents may be helped considerably by having an understanding of the baby's difficulty in regulating their state themselves, and in this way the parents may be able to tolerate giving the kind of support such babies require much more willingly. The baby might, for example, need input from several modalities to contain them: for example, ventral contact and movement, such as in actively rocking the baby.

- **Reducing stimulation**

Alternatively, there are babies who also become disorganised and distressed when needing to sleep, but who require a reduction in stimulation. Trying to intervene actively with such babies may make them even more agitated, and it may be observed that these babies will calm better if all stimulation is cut right down.

Whichever strategy is used to help the baby move into a sleep state, he may find it helpful to have next to him a cloth or cover that has been in contact with his mother and which therefore carries her smell.

4. Crying and consolability (discussion)

- Understanding crying
- Strategies for consoling a crying baby

Understanding crying

Crying is normal for babies. All babies cry. It is a clear form of communicating needs and is essential for survival.

A baby does not cry because s/he is "naughty" but because of one of the following reasons:

- Hunger
- Tiredness
- Over-stimulation
- Discomfort caused by a dirty nappy; digestive disturbances such as cramps, bloating, reflux; indigestion, constipation, diarrhoea, over-feeding, medical conditions, allergies, being too hot or too cold.
- Feeling lonely- the need to be touched, soothed and spoken to

Babies differ in how much they cry. Some babies cry for an hour altogether in a whole day whilst other babies cry for a couple hours unceasingly.

Research has shown that there can be quite a big difference in how much a baby cries and how much the mother expects her baby to cry.

There can also be quite a big difference in how much the baby is **actually crying** and **how much the baby seems to be crying**. For example, a baby may be crying for 1 hour altogether in a day but it might seem to the mother that the baby has been crying the whole day.

Crying evokes powerful emotions. It can evoke joy (e.g. when the mother hears her baby crying for the first time). It can also evoke anger; frustration; rage; disappointment, etc.

How a mother copes with crying and how much crying it takes to push her to the point of desperation, also differs from one mother to the next.

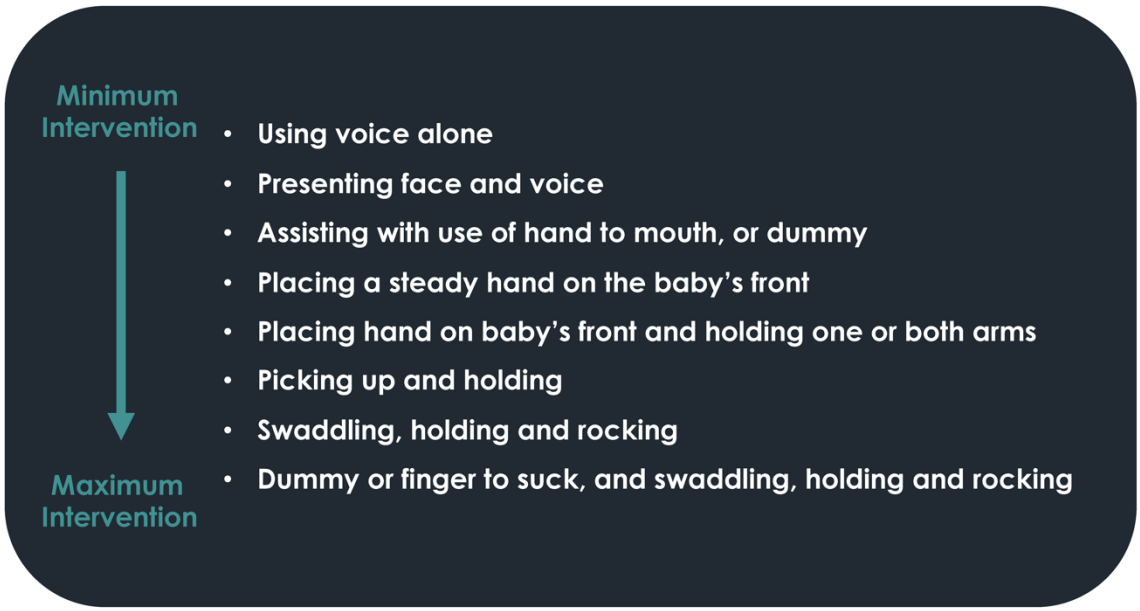
All mothers want to settle their babies as quickly as possible.

Strategies for consoling a crying baby

The principles that apply to the management of the transition to sleep apply similarly to baby crying. That is, there should be careful observation of the individual baby's behaviour in order to build up a picture of the circumstances that both provoke and relieve crying.

Strategies found to be effective for settling the baby to sleep are also likely to be relevant to relieving crying. However, whereas parents may often want to avoid getting in to a pattern of having to intervene directly with the infant through the transition to sleep, this will almost certainly not be an issue with consoling the infant.

The following strategies, therefore, while using the same understanding of the infant's use of different stimulation for regulating their state, involve direct personal intervention by the parents. **They progress from minimum to maximum direct intervention:**



It is important for the mother to be aware that, as with sleep strategies, some infants may become more distressed with additional stimulation.

In such cases, as for sleep, the infant may be better calmed by being left in a quiet semi-dark environment, checking of course to make sure that the baby is all right.

Decisions about the best strategy to try will be most effective when based on detailed observation of the individual baby's responses.

There are no universal rules, other than that the mother must be guided by the unique patterns of behaviour of her baby.

7. Wider concerns (note and comment)

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available.

Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

8. Arrangements for next visit

Arrangements must be made for the next visit.

SESSION 5

Timing:	Postnatal Visit 3 (day 17-21)
Agenda:	1. Tuning in to the mother 2. The Behavioural and Interactive Assessment of the Baby (BAIB) 3. Sleeping (discussion) 4. Crying and Consolability (discussion) 5. Wider Concerns (note and comment) 6. Arrangements for Next Visit

Activities:

1. Tuning in to the mother

- Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
- When you feel that the mother has had sufficient time to express all her **concerns,** gradually and with sensitivity, introduce the other issues on your own agenda for the session.

2. Completion of the BAIB

While you will not on this occasion formally perform the Behavioural Interactive Assessment of the Baby (BAIB), you might want to complete certain items of the assessment that could not be completed in the previous session.

3. Sleeping (discussion)

Discuss the baby's sleeping. Refer to the Postnatal visit 2 notes on sleeping.

4. Crying and consolability (discussion)

Discuss the baby's crying and how the mother is managing with it. Refer to the Postnatal visit 2 notes on crying.

5. Wider concerns (note and comment)

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

6. Ending off and arrangements for the next visit

Arrangements must be made for the next visit.

Remember to arrange for the next visit to be at bath time so that you can demonstrate baby massage for the mother. You should discuss with her whether her partner, or older children, or any other important figure in her life who might be involved with the care of the baby, could be present.

SESSION 6	
Timing:	Postnatal Visit 4 (4 weeks)
Agenda:	1. Tuning in to the mother 2. Sleeping (discussion) 3. Crying and Consolability (discussion) 4. Wider Concerns (note and comment) 5. Arrangements for Next Visit

Activities:

1. Tuning in to the mother

- Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
- When you feel that the mother has had sufficient time to express all her **concerns,** gradually and with sensitivity, introduce the other issues on your own agenda for the session.

2. Sleeping (discussion)

Discuss the baby's sleeping. Refer to the Postnatal visit 2 notes on sleeping.

3. Crying and consolability (discussion)

Discuss the baby's crying and how the mother is managing with it. Refer to the Postnatal visit 2 notes on crying.

4. Wider concerns (note and comment)

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

5. Ending off and arrangements for the next visit

Arrangements must be made for the next visit.

The mother should be reminded that at the next visit you will be carrying out the Behavioural Interactive Assessment of the Baby again.

You should discuss with her whether her partner, or older children, or any other important figure in her life who might be involved with the care of the baby, could be present.

SESSION 7

Timing:	Postnatal Visit 5 (5 weeks)
Agenda:	1. Tuning in to the mother 2. The Behavioural and Interactive Assessment of the Baby (BAIB) 3. Sleeping (discussion) 4. Crying and Consolability (discussion) 5. Wider Concerns (note and comment) 6. Arrangements for Next Visit

Activities:

1. Tuning in to the mother

- Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
- When you feel that the mother has had sufficient time to express all her **concerns,** gradually and with sensitivity, introduce the other issues on your own agenda for the session.

2. The Behavioural and Interactive Assessment of the Baby (BAIB)

This assessment should be repeated in full (all 10 components).

The baby's development over the weeks can be seen and should be highlighted. In the light of these changes, you should review with the mother strategies for care giving.

Give special attention to the social interaction items. Emphasise any social responsiveness shown to the mother.

3. Sleeping (discussion)

Discuss the baby's sleeping. Refer to the Postnatal visit 2 notes on sleeping.

4. Crying and consolability (discussion)

Discuss the baby's crying and how the mother is managing with it. Refer to the Postnatal visit 2 notes on crying.

5. Wider concerns (note and comment)

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

6. Ending off and arrangements for the next visit

Arrangements must be made for the next visit.

SESSION 8

Timing:	Postnatal Visit 6 (6 weeks)
Agenda:	1. Tuning in to the mother 2. The Behavioural and Interactive Assessment of the Baby (BAIB) 3. Sleeping (discussion) 4. Crying and Consolability (discussion) 5. Wider Concerns (note and comment) 6. Arrangements for Next Visit

Activities:

1. Tuning in to the mother

- Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
- When you feel that the mother has had sufficient time to express all her **concerns,** gradually and with sensitivity, introduce the other issues on your own agenda for the session.

2. The Behavioural and Interactive Assessment of the Baby (BAIB)

On this visit, components 9 (imitation and responsiveness) and 10 (social interactive package) of the BAIB will be repeated.

As the visits progress, the emphasis needs to focus more and more on the social interactive items of the assessment – the imitation, sensitive responsiveness on the part of the mother or father towards the baby, reciprocal games and other conversations or communications, and thinking and reflecting on how you understand the baby's behaviour.

You will need to model face-to-face interactions in the form of reciprocal and sensitive exchanges with the baby and look for opportunities to comment on the mother's and father's sensitive and reciprocal face-to-face interactions with the baby when they occur.

You may also need to help the mother to position the baby to facilitate engagement during feeding and at other times.

3. Sleeping (discussion)

Discuss the baby's sleeping. Refer to the Postnatal visit 2 notes on sleeping.

4. Crying and consolability (discussion)

Discuss the baby's crying and how the mother is managing with it. Refer to the Postnatal visit 2 notes on crying.

5. Wider concerns (note and comment)

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

6. Ending off and arrangements for the next visit

Arrangements must be made for the next visit.

Remember to arrange for the next visit to be at bath time so that you can demonstrate baby massage for the mother. You should discuss with her whether her partner, or older children, or any other important figure in her life who might be involved with the care of the baby, could be present.

SESSION 9	
Timing:	Postnatal Visit 7 (7 weeks)
Agenda:	1. Tuning in to the mother 2. The Behavioural and Interactive Assessment of the Baby (BAIB) 3. Sleeping (discussion) 4. Crying and Consolability (discussion) 5. Wider Concerns (note and comment) 6. Arrangements for Next Visit

Activities:

1. Tuning in to the mother

- Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
- When you feel that the mother has had sufficient time to express all her **concerns,** gradually and with sensitivity, introduce the other issues on your own agenda for the session.

At all times be aware and ready to recognize, point out and praise any positive, sensitive, responsive, loving, attuned, observant, emotionally expressive communication and interaction between the mother/caregiver and the child.

2. The Behavioural and Interactive Assessment of the Baby (BAIB)

Repeat aspects of the Behavioral Interactive Assessment of the Baby, especially those highlighting infant social responsiveness.

3. Sleeping (discussion)

Discuss the baby's sleeping. Refer to the Postnatal visit 2 notes on sleeping.

4. Crying and consolability (discussion)

Discuss the baby's crying and how the mother is managing with it. Refer to the Postnatal visit 2 notes on crying.

5. Wider concerns (note and comment)

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

6. Ending off and arrangements for the next visit

Arrangements must be made for the next visit.

SESSION 10	
Timing:	Postnatal Visit 8 (8 weeks)
Agenda:	1. Tuning in to the mother 2. The Behavioural and Interactive Assessment of the Baby (BAIB) 3. Sleeping (discussion) 4. Crying and Consolability (discussion) 5. Wider Concerns (note and comment) 6. Arrangements for Next Visit

Activities:

1. Tuning in to the mother

- Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
- When you feel that the mother has had sufficient time to express all her **concerns,** gradually and with sensitivity, introduce the other issues on your own agenda for the session.

2. The Behavioural and Interactive Assessment of the Baby (BAIB)

Run through the full assessment (all 10 components) for the last time. Ask the mother to tell you about all the changes she has seen and pointing out how much development you have noticed.

3. Sleeping (discussion)

Discuss the baby's sleeping. Refer to the Postnatal visit 2 notes on sleeping.

4. Crying and consolability (discussion)

Discuss the baby's crying and how the mother is managing with it. Refer to the Postnatal visit 2 notes on crying.

5. Wider concerns (note and comment)

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

6. Ending off and arrangements for the next visit

Arrangements must be made for the next visit.

Remind the mother or caregiver that as from next week your visits will only be every second week and then once a month from the fourth month. Explore and allow her to express her feelings about this change of routine.

SESSION 11

Timing:	Postnatal Visit 9 (10 weeks)
Agenda:	1. Tuning in to the mother 2. **Encouraging social interaction between mother and baby** 3. Sleeping (discussion) 4. Crying and Consolability (discussion) 5. Wider Concerns (note and comment) 6. Arrangements for Next Visit

Activities:

1. Tuning in to the mother

- Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
- When you feel that the mother has had sufficient time to express all her **concerns,** gradually and with sensitivity, introduce the other issues on your own agenda for the session.

2. Encouraging social interaction between mother and baby

The focus of the visits now shifts substantially to encouraging social interactions between the mother or caregiver and the baby.

Take advantage of the infant's pre-speech developing at this time and his or her fascination with mother's face and eyes. You will model face-to-face interactions and sensitive reciprocal exchanges in the form of verbal and non-verbal conversations with the baby. Comment to the baby about what is going on around her or him and reflecting on how baby might be experiencing this.

Try to find an opportunity to see the mother interact face-to-face with the baby. Help the mother to position the baby to facilitate social engagement.

3. Sleeping (discussion)

Discuss the baby's sleeping. Refer to the Postnatal visit 2 notes on sleeping.

4. Crying and consolability (discussion)

Discuss the baby's crying and how the mother is managing with it. Refer to the Postnatal visit 2 notes on crying.

5. Wider concerns (note and comment)

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

6. Ending off and arrangements for the next visit

Arrangements must be made for the next visit.

Remind the mother that your visits will only be every second week and then once a month from the fourth month. Explore and allow her to express her feelings about this change of routine.

SESSION 12

Timing:	Postnatal Visit 10 (12 weeks)
Agenda:	1. Tuning in to the mother 2. Encouraging social interaction between mother and baby 3. Sleeping (discussion) 4. Crying and Consolability (discussion) 5. Wider Concerns (note and comment) 6. Arrangements for Next Visit

Activities:

1. Tuning in to the mother

- Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
- When you feel that the mother has had sufficient time to express all her **concerns,** gradually and with sensitivity, introduce the other issues on your own agenda for the session.

2. Encouraging social interaction between mother and baby

Take advantage of the infant's pre-speech developing at this time and his or her fascination with mother's face and eyes. You will model face-to-face interactions and sensitive reciprocal exchanges in the form of verbal and non-verbal conversations with the baby. Comment to the baby about what is going on around her or him and reflecting on how baby might be experiencing this.

Try to find an opportunity to see the mother interact face-to-face with the baby. Help the mother to position the baby to facilitate social engagement.

3. Sleeping (discussion)

Discuss the baby's sleeping. Refer to the Postnatal visit 2 notes on sleeping.

4. Crying and consolability (discussion)

Discuss the baby's crying and how the mother is managing with it. Refer to the Postnatal visit 2 notes on crying.

5. Wider concerns (note and comment)

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

6. Ending off and arrangements for the next visit

Remind the mother that after your next session, you will then be visiting her on a monthly basis. Explore and allow her to express her feelings about this change of routine.

SESSION 13

Timing:	Postnatal Visit 11 (14 weeks)
Agenda:	1. Tuning in to the mother 2. Encouraging social interaction between mother and baby 3. Sleeping (discussion) 4. Crying and Consolability (discussion) 5. Wider Concerns (note and comment) 6. Arrangements for Next Visit

Activities:

1. Tuning in to the mother

- Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
- When you feel that the mother has had sufficient time to express all her **concerns,** gradually and with sensitivity, introduce the other issues on your own agenda for the session.

2. Encouraging social interaction between mother and baby

Take advantage of the infant's pre-speech developing at this time and his or her fascination with mother's face and eyes. You will model face-to-face interactions and sensitive reciprocal exchanges in the form of verbal and non-verbal conversations with the baby. Comment to the baby about what is going on around her or him and reflecting on how baby might be experiencing this.

Try to find an opportunity to see the mother interact face-to-face with the baby. Help the mother to position the baby to facilitate social engagement.

3. Sleeping (discussion)

Discuss the baby's sleeping. Refer to the Postnatal visit 2 notes on sleeping.

4. Crying and consolability (discussion)

Discuss the baby's crying and how the mother is managing with it. Refer to the Postnatal visit 2 notes on crying.

5. Wider concerns (note and comment)

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available.

6. Ending off and arrangements for the next visit

Remind the mother that you will now be visiting her on a monthly basis. Explore and allow her to express her feelings about this change of routine.

SESSION 14

Timing:	Postnatal Visit 12 (16 weeks / 4 months)
Agenda:	1. Tuning in to the mother 2. Encouraging social interaction between mother and baby 3. Sleeping (discussion) 4. Crying and Consolability (discussion) 5. Wider Concerns (note and comment) 6. Arrangements for Next Visit

Activities:

1. Tuning in to the mother

- Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
- When you feel that the mother has had sufficient time to express all her **concerns,** gradually and with sensitivity, introduce the other issues on your own agenda for the session.

2. Encouraging social interaction between mother and baby

Discuss changes in the baby's social responsiveness with the increase in maturity. The baby's eyesight has developed, and the baby can now see better at a distance. This will mean his interest will shift away from just playing face-to-face, to events and objects further away.

The mother's understanding this shift and noticing the baby's new interests, will allow her to respond sensitively in new ways: following the infant's interest, starting to play simple body games, such as, 'peek-a-boo' and 'round and round the garden'.

3. Sleeping (discussion)

Discuss the baby's sleeping. Refer to the Postnatal visit 2 notes on sleeping.

4. Crying and consolability (discussion)

Discuss the baby's crying and how the mother is managing with it. Refer to the Postnatal visit 2 notes on crying.

5. Wider concerns (note and comment)

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available.

6. Ending off and arrangements for the next visit

Remind the mother that you only have two more visits before this programme comes to an end.

SESSION 15	
Timing:	Postnatal Visit 13 (20 weeks / 5 months)
Agenda:	1. Tuning in to the mother 2. Encouraging social interaction between mother and baby 3. Sleeping (discussion) 4. Crying and Consolability (discussion) 5. Wider Concerns (note and comment) 6. Arrangements for Next Visit

Activities:

1. Tuning in to the mother

Remind the mother at the beginning of this session that you only have one visit left before this programme comes to an end.

- Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.

- When you feel that the mother has had sufficient time to express all her **concerns,** gradually and with sensitivity, introduce the other issues on your own agenda for the session.

2. Encouraging social interaction between mother and baby

Now the baby will be able to reach out and grab things nearby; again if the mother follows the baby's cues, she can use this new development to have different social experiences with her baby that will hold the baby's interest and give enjoyment.

3. Sleeping (discussion)

Discuss the baby's sleeping. Refer to the Postnatal visit 2 notes on sleeping.

4. Crying and consolability (discussion)

Discuss the baby's crying and how the mother is managing with it. Refer to the Postnatal visit 2 notes on crying.

5. Wider concerns (note and comment)

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available.

6. Ending off and arrangements for the next visit

Despite the best preparation there will be mothers who will have very strong feelings of abandonment and sadness about this ending. You need to be aware of this even though this may not be conscious in the mother or expressed openly to you. Remind the mother that as part of the study there will be further assessments of her and her baby and this will provide her with further opportunities to express any concerns she may have.

SESSION 16

Timing:	Postnatal Visit 14 (24 weeks / 6 months)
Agenda:	1. Tuning in to the mother 2. Encouraging social interaction between mother and baby 3. Sleeping (discussion) 4. Crying and Consolability (discussion) 5. Wider Concerns (note and comment) 6. Saying goodbye

Activities:

1. Tuning in to the mother

- Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
- When you feel that the mother has had sufficient time to express all her **concerns,** gradually and with sensitivity, introduce the other issues on your own agenda for the session.

2. Encouraging social interaction between mother and baby

Now the baby will be able to reach out and grab things nearby; again if the mother follows the baby's cues, she can use this new development to have different social experiences with her baby that will hold the baby's interest and give enjoyment.

3. Sleeping (discussion)

Discuss the baby's sleeping. Refer to the Postnatal visit 2 notes on sleeping.

4. Crying and consolability (discussion)

Discuss the baby's crying and how the mother is managing with it. Refer to the Postnatal visit 2 notes on crying.

5. Wider concerns (note and comment)

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available.

6. Saying goodbye

You will need to say goodbye to the mother and her baby and the others with whom you have worked in the household. It might be helpful to review, with the mother, what this has meant to her and what she feels she has learnt through the process.