

## Dominique Haumont PhD

Introduction by Joy Browne, PhD

Dominique Haumont has been a trendsetter and a visionary when individualized, developmental care was not typical in most Belgian Newborn Intensive Care Units (NICU), or for that matter, in many NICUs world-wide. I have watched in amazement at how she has uniquely and sensitively brought about changes in her own hospital, in her country and in international settings. The vision of making sure babies and their mothers are never separated, her original goal, reflects an inspiration and has now been realized through her efforts over the last three decades. Her novel and progressive approaches to making system change happen have been not only effective, but have given us a template for what can be achieved. They are reflective of our collective knowledge that change does not happen fast, but with perseverance and sensitivity it can be accomplished. We have much to learn from her stories of accomplishments, her perseverance and her ability to think “outside the box”. She is an enabler, a visionary and a true friend. Thank you, Dominique, for sharing the story of your journey with us.

During my pediatric specialty training (1975-80), I was already preoccupied by the mother infant separation in the children’s wards and in the Newborn Intensive Care Unit. At that time, fetal medicine was developing very fast and I started a very close collaboration with the obstetricians/midwives where I was working at the university hospital. Our first approach to studying the behaviour of the preterm infant was to compare their intra-uterine behavior observed by ultrasound (eye movements, general movements, respiration, etc.) with sleep-wake cycles after birth by polysomnography. This was my first understanding of ontogeny of sleep in the 1980’s.

In the 1980’s it was not yet understood that the proximity of mothers and babies had implications beyond the technical aspects. There were two approaches in those days: on the one hand the development of perinatal centers to keep high risk pregnancies in the proximity of well-equipped NICUs. On the other hand, many pediatricians were fighting for children’s hospitals centralising pediatric expertise, especially for artificial ventilation. I tried very hard to convince the hospital authorities that sick newborns in the obstetric department needed to have building plans that included access to a NICU next to the delivery room. It took them 20 years to come to that idea on their own. I left in 1985 and moved to Saint-Pierre University Hospital where there was no plan to move the NICU away from the delivery room.

From the beginning, I shared with the vast majority of the nursing staff the need to move away from traditions like visiting hours for parents, lack of attention to pain during procedures, uncomfortable positioning and/or no respect of sleep cycles. In the late 1980’s and 1990’s, we initiated skin to skin, positioned the babies in hammocks, tried to reduce painful procedures by



*Dominique Haumont: Her Story of System Change and Implementation*

suppressing routine blood sampling and allowed permanent parental presence. All these approaches were quite innovative at the time.

When I supported the practice of permanent parental presence, I was called by the Head of the Department of Pediatrics asking me to stop, because he did not want it to happen in all the wards. I told him that these were the new official recommendations of the Scientific Societies of Neonatology. That was of course not true. I bluffed and it worked! The suffering of the mother having a baby in the NICU appeared so deep to me that I started a collaboration with the psychiatrists and psychologist to have a professional vision for parental mental health support in the NICU.

I also had the idea of not only diminishing pain and stress but including some policies that related to promotion of “well-being”. We started a study having babies listening to music or mother’s voice and recorded the reactions on video and observation sheets. Unfortunately, because of lack of staff we could not conduct the study that would have provided relevant conclusions and publications, but we had observed that each baby had his individual pattern of response to that auditory stimulus.

During those days, I realized that I had to contribute to neonatal research in a traditional way in order to insure the credibility of the unit and of the novel approaches to NICU care. My papers on nutrition and surfactant were published and I was a member of numerous scientific societies which contributed to the realization that our research was credible and necessary. Simultaneously, pushed forward by Jacques Sizun from Brest, a European group “The Early Developmental Care Network” contributed to the general sensitivities and need for culture change in the European units (see article *Developmental Observer*, Vol. 3, No. 2, 2009). Through this group’s efforts we conducted and

published several surveys about practices in NICUs in Europe.

Being interested in the assessment of babies' behaviour I found a publication from Björn Westrup in 1997 where he described what happened in his unit in Falun. He had returned from the United States (US) and introduced NIDCAP in Europe. This approach appeared to me to be the one we needed to structure teaching of developmental care.

From the beginning of implementing the Newborn Individualized Developmental Care and Assessment Program (NIDCAP) work, I wanted our unit to become a Training Center. It seemed the most efficient way to assure the consistency of the change we aimed for in the newborn units.

My role in supporting NIDCAP was first finding the funding, explaining to the staff about the need for sensitive developmental care, and also explaining in national conferences why we had to change. Since the beginning of the NIDCAP journey, I have put enormous efforts into finding the necessary funding for sending collaborators to the US, hosting NIDCAP and APIB trainers in Brussels and achieving the steps for becoming a NIDCAP Training Center. Two major personal grant applications (in 1999 and 2002) gave me the necessary financial support to start building the Brussels Training Center.

As Head of the Neonatal Unit, and also having national and international commitments I could not enter the training process myself, but I had been the translator (French-English) for many observations of the trainees. This provided me the opportunity to infuse NIDCAP approaches on a daily basis by integrating the new vision in organizing the care and encouraging consideration of parents to be collaborators with staff. We had all kinds of working groups among which Early Developmental Care with a weekly discussion around specific aspects of implementing NIDCAP in the unit.

Delphine Druart engaged herself in the process and appeared to have the qualities of an exceptional trainer. She consistently worked toward and was successful at becoming a NIDCAP Professional and then a NIDCAP Trainer. Once the Training Center was opened, we wanted the unit to be an example to other Belgian units. Despite Delphine being called for training in many other NICUs in Belgium and France, she insured and verified our level of NIDCAP care on a regular basis. I must say, the whole staff was very supportive of our efforts, including the obstetricians.

Due to the context of the different university NICUs in Brussels, I started with a small unit and was very close to the families. My resulting partnerships with parents have been very intense. Together we created an association "NeoNid" to promote NIDCAP and family-centered care. I have been very lucky to work with neonatologists to whom I delegated the tasks in the caregiving; one of the reasons they worked in Saint Pierre Hospital was because of the innovative approach of family-centered care. Our unit and the staff grew and the unit ended up being the biggest in Brussels. I became the conductor of the whole team.

While we were building our Training Center, we experienced growing interest inside Belgium and Europe towards Early Developmental Care, whether it was NIDCAP or something

different. The variety of approaches aimed to provide proximity between families and include other elements of Early Developmental Care. Having started the movement of these approaches concretely in the NICU, I was invited to talk about our experience in many hospitals or meetings. Often many visitors came to see how we had implemented our caregiving approaches.

In Belgium, the Ministry of Health appointed, by law, "Colleges of Physicians" to insure quality control. Being a member

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and then the President of the College of Neonatology (2008-2013), I had close contact with the Ministry's administration. I knew they were implementing incentives to increase breastfeeding rates by supporting the Baby Friendly Hospital Initiative (BFHI), and that mother infant closeness was accepted as being an important issue. I went several times to see our authorities where I presented the evidence for moving away from potential harmful traditional NICU environments. They understood the need for a structured tool to achieve our goals toward family centered care and agreed that the program which was the most evaluated was the NIDCAP approach. We obtained a four year contract (2006-2010) between the hospital and the Ministry to increase the staff. Once the Training Center was opened, other hospitals could apply for and obtain financial support to benefit from our teaching. They could combine BFHI and/or NIDCAP.

It took roughly from 1985 to 2010 (25 years) to reach maturity of the concept. The proximity of the parents with their infant is the key issue, and without appropriate environmental supports and policies it is very difficult to apply. We started, like everywhere else, with common (often crowded) rooms and the very first fight was to obtain space for a comfortable chair for kangaroo mother care. When the NICU had to be rebuilt, the hospital directors decided to send me and some NICU parents to one of the Florida conferences about NICU design which Dr. Joy Browne was co-organizing. The newly built NICU opened in 2005. With the new design we could host mothers on a small bed in the single rooms. At that time it was quite progressive, but I already started to prepare the next step which was the concept of "couplet care" with a big family room. This process is still ongoing, but since it started, I have retired.

Initiating that extent of change in the NICU was not an easy task and it was very challenging. The most important chal-

lenge to me was to be sure I was going the right direction. In the masculine world of scientific societies the issues on developmental care were not very popular. It was considered important for nurses or for emotional issues of parents but not really science.

Having understood that about my profession, I presented to my colleagues the impact of the different elements of EDC and NIDCAP separately. There is scientific interest for pain, for colostrum, for effect of light and noise, for later outcomes and so forth. Presenting the work in that way has proven to gain more interest. However, I still think that we cannot study NIDCAP easily because the sophisticated level of implementation and priorities of the program are difficult to measure.

The other challenges I faced were comparable to “normal”

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challenges of the head of a department. As head, I continually faced personal and relationship issues within the staff. A NICU has very difficult periods when facing death, malformations, impairment, etc. It is very important to take care of emotions or feelings of patients, but the staff need special attention too, and sometimes psychological support. Introducing NIDCAP provided positive returns from the team and I felt happy to have a happy staff most of the time.

I have so many good memories of my life as Head of the NICU in Saint-Pierre. The teamwork to provide a different way of caring is probably what made me most happy. Initiatives taken by staff members and parents feeling at home are a few examples of what made me feel good.

The situation has evolved, so many things which were “avant-garde” have become routine. With the foundation that I have described, the future of the Training Center in Brussels now relies on the new team directing the unit. They will decide what they want at local, national and international level. They have the skills.

Personally, I am now running an international network eNewborn, registering data on Very Low Birth Weight Infants. I again want to move away from the traditional approach of looking at data. For instance, I think parents could, on a voluntary basis, provide information using special Apps. PREM (Patient Reported Experience Measure) and PROM (Patient Reported Outcome Measure) could be a next step telling us how families see things.

— Dominique Haumont  
Brussels, May 28, 2019



## Mission

The NFI promotes the advancement of the philosophy and science of NIDCAP care and assures the quality of NIDCAP education, training, mentoring and certification for professionals, and hospital systems.

*Adopted by the NFI Board, July 1, 2019*

## Vision

The NFI envisions a global society in which all hospitalized newborns and their families receive care in the evidence-based NIDCAP model. NIDCAP supports development, enhances strengths and minimizes stress for infants, family and staff who care for them. It is individualized and uses a relationship-based, family-integrated approach that yields measurable outcomes.

*Adopted by the NFI Board, October 20, 2017*