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Compilation

« Accouchement à domicile et Maisons de Naissance »

Base de données de l'AFAR
http://afar.info

Etude réalisée le 8 novembre 2006

Compilation
« Accouchement à domicile et Maisons de Naissance »

Méthode de travail : Nous avons sélectionné les 47 fiches répondant aux mots-clés « accouchement à domicile » ou « maisons de naissance » dans la base de données de l'AFAR, le 8 novembre 2006. La base peut être interrogée directement à partir de la page **http://afar.info/biblio-liens.htm**

Cette compilation ne prétend pas à l'exhaustivité car nous n'avons pas encore fait de recherche systématique de la littérature scientifique sur ces thèmes. D'autre part, certaines études citées ne sont pas focalisées principalement sur les deux thèmes. Nous invitons les lecteurs à nous signaler d'autres études ou à les saisir directement dans la base de données. Contacter **afar(arobase)fraternet.org**.

Convention : Le numéro entre [crochets] est celui de la fiche dans la base de données.

	[1992] Objective: to explore the culture, beliefs, values, customs and practices around the birth process within a free-standing birth centre (FSBC). Design: ethnography. Setting: a birth centre situated in the midlands of England. Participants: women attending the centre, midwives and maternity-care assistants(MCAs) working at the centre. Findings: women in the study seemed to invoke intuitive nesting-related behaviours in their assessment of the suitability of the birth centre. In addition, the birth centre staff's focus on creating the right ambience for birth may also emanate from nesting concerns. Birth-centre staff assisted women through the 'becoming mother' transition, which is conceptualised as 'matrescent' care. Key conclusions: the birth-centre environment elicited nesting-like behaviours from both women and staff. This formed part of a nurturing orientation that was conceptualised as 'matrescent' (becoming mother) care. 'Matrescence' does not seem to be grounded in clinical skills but is relationally mediated. Implications for practice: nesting-like behaviours and 'matrescent' care in this context challenge maternity services to review traditional conceptualisations of safety and traditional expressions of clinical intrapartum care.

	Denis J. Walsh. 'Nesting' and 'Matrescence' as distinctive features of a free-standing birth centre in the UK. Midwifery (2006) 22, 228–239. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=16713045&query_hl=1&itool=pubmed_docsum
Rien ne prouve que l'AAD soit plus dangereux que l'accouchement hospitalier pour des femmes sélectionnées avec grossesse à bas risque.	[1278] En France l'accouchement à domicile (AAD) est choisi par une minorité de femmes et cette possibilité est revendiquée par les associations de parents et les sages-femmes libérales qui le pratiquent. Pourtant cette option est présentée comme à risque élevé par le personnel hospitalier. À tort ? Après analyse des nombreuses études scientifiques sur le sujet, rien ne prouve que l'AAD soit plus dangereux que l'accouchement hospitalier, pour des femmes sélectionnées avec grossesse à bas risque. De plus cette alternative permet une réduction des interventions médicales et de la morbidité maternelle tout en améliorant la satisfaction des femmes. L'optimisation des soins obstétricaux en France pourrait passer par une amélioration de la prise en charge hospitalière en s'inspirant des concepts qui justifient l'AAD mais aussi par une promotion de celui-ci pour des femmes sélectionnées qui le souhaitent. Ceci nécessite de repenser le métier de sage-femme. Ces changements apporteraient une solution aux problèmes actuels : la nécessité d'améliorer la sécurité périnatale en minimisant les interventions, le manque d'obstétriciens et d'anesthésistes, et l'économie de santé. **PIREYN-PIETTE, Cathy-Anne. Accouchement à domicile: risque ou modèle? Mémoire pour le Diplôme d'Etat de Sage-Femme, Université Louis Pasteur, Faculté de médecine / Ecole de sages-femmes de Strasbourg, 2 mai 2005.** http://naissance.ws/memoires/Cathy-AnnePiette.pdf
Aux USA, les accouchements planifiés à domicile pour les grossesses à faible risque sont associés à la même sécurité et à moins d'interventions que les accouchements à faible risque en hôpital. (Etude de plus de 5000	[1284] Planned home births for low risk women in the United States are associated with similar safety and less medical intervention as low risk hospital births, finds a study in this week's BMJ. Midwives involved with home births are often not well integrated into the healthcare system in the United States and evidence on the safety of such home births is limited. In the largest study of its kind internationally to date, researchers analysed over 5000 home births involving certified professional midwives across

accouchements à domicile aux E-U et au Canada) Planned home births for low risk women in the United States are associated with similar safety and less medical intervention as low risk hospital births.	the United States and Canada in 2000. Outcomes and medical interventions were compared with those of low risk hospital births. Rates of medical intervention, such as epidural, forceps and caesarean section, were lower for planned home births than for low risk hospital births. Planned home births also had a low mortality rate during labour and delivery, similar to that in most studies of low risk hospital births in North America. A high degree of safety and maternal satisfaction were reported, and over 87% of mothers and babies did not require transfer to hospital. "Our study of certified professional midwives suggests that they achieve good outcomes among low risk women without routine use of expensive hospital interventions," say the authors. "This evidence supports the American Public Health Association's recommendation to increase access to out of hospital maternity care services with direct entry midwives in the United States." ------- Objective To evaluate the safety of home births in North America involving direct entry midwives, in jurisdictions where the practice is not well integrated into the healthcare system. Design Prospective cohort study. Setting All home births involving certified professional midwives across the United States (98% of cohort) and Canada, 2000. Participants All 5418 women expecting to deliver in 2000 supported by midwives with a common certification and who planned to deliver at home when labour began. Main outcome measures Intrapartum and neonatal mortality, perinatal transfer to hospital care, medical intervention during labour, breast feeding, and maternal satisfaction. Results

	655 (12.1%) women who intended to deliver at home when labour began were transferred to hospital. Medical intervention rates included epidural (4.7%), episiotomy (2.1%), forceps (1.0%), vacuum extraction (0.6%), and caesarean section (3.7%); these rates were substantially lower than for low risk US women having hospital births. The intrapartum and neonatal mortality among women considered at low risk at start of labour, excluding deaths concerning life threatening congenital anomalies, was 1.7 deaths per 1000 planned home births, similar to risks in other studies of low risk home and hospital births in North America. No mothers died. No discrepancies were found for perinatal outcomes independently validated. Conclusions Planned home birth for low risk women in North America using certified professional midwives was associated with lower rates of medical intervention but similar intrapartum and neonatal mortality to that of low risk hospital births in the United States **Kenneth C Johnson; Betty-Anne Daviss. Outcomes of planned home births with certified professional midwives: large prospective study in North America. BMJ 2005;330:1416** http://bmj.bmjjournals.com/cgi/content/full/330/7505/1416?ehom Remarques : Further Information from co-author Betty-Anne Daviss: The study shows that -- if you aren't a high risk Mom carrying twins, having a premature baby or baby coming bottom first, all of which can be judged ahead of time -- your chance of having a healthy normal safe delivery are the same whether you plan a home or hospital birth. However, if you choose the home birth your intervention rates will be a tenth to a half of what they would be in hospital, compared to figures of the same time period from the National Health Institute of the US. The study is groundbreaking because former studies have been criticized for not being big enough, for not being able to distinguish between planned or unplanned births, and for being retrospective, that is only looking at old records as opposed to engaging health professionals in the requirement of registering births they were going to do and then having to account for all outcomes. As well,

	over 500 mothers were phoned to verify whether what the midwives said at the births actually happened. The study suggests that legislators and policy makers should pay attention to the fact that this study supports the American Public Health Association resolution to increase out of hospital births done by direct entry midwives. The American College of Obstetricians and Gynecologists still opposes home birth. The SOGC has written a statement acknowledging that women have the right to choose their place of birth.
l'ocytocine de plus en plus utilisée en Inde rurale lors des AADs.	[1308] OBJECTIVE: To examine factors associated with the use of oxytocin for acceleration of labor in women delivered at home in rural India. METHOD: Quantitative data were collected from 527 women who were delivered at home and qualitative interviews were carried out with 21 mothers and 9 birth attendants. RESULTS: Oxytocin use was associated with higher education and socioeconomic status, primigravidity, and delivery by a traditional birth attendant. CONCLUSION: Labor acceleration with oxytocin occurs indiscriminately In India. Oxytocin use should be regulated, and training for birth attendants should be provided as well as health education for pregnant women. **Sharan M, Strobino D, Ahmed S. Intrapartum oxytocin use for labor acceleration in rural India. {Inde}. International Journal of Gynecology & Obstetrics 2005;90(3):251-257.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=16023648&query_hl=9
Les futurs parents choissisant l'AAD sont conscient des risques, mais se sont bien préparés et ont confiance en eux et leur sage-femme.	[1349] OBJECTIVE: to describe home-birth risk assessment by parents. DESIGN: interviews using a semi-structured interview guide. Data were analysed using a phenomenological approach. SETTING: independent midwifery practices in Sweden. PARTICIPANTS: five couples who had had planned home births. FINDINGS: the parents had a fundamental trust that the birth would take place without complications, and they experienced meaningfulness in the event itself. Risks were considered to be part of a complex phenomenon that was not limited to births at home. This attitude seems to be part of a lifestyle that has a bearing on how risks experienced during the birth were handled. Five categories were identified as counterbalancing the risk of possible complications: (1) trust in the woman's ability to give birth; (2) trust in intuition; (3) confidence in the midwife; (4)

	confidence in the relationship; and (5) physical and intellectual preparation. KEY CONCLUSIONS: although the parents were conscious of the risk of complications during childbirth, a fundamental trust in the woman's independent ability to give birth was central to the decision to choose a home birth. Importance was attached to the expected positive effects of having the birth at home. IMPLICATIONS FOR PRACTICE: knowledge of parents' assessment can promote an increased understanding of how parents-to-be experience the risks associated with home birth. **Lindgren H, Hildingsson I, Radestad I. A Swedish interview study: parents' assessment of risks in home births.** **Midwifery. 2005 Aug 25. [Epub ahead of print]** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=16125827&query_hl=1
	[1350] This paper explores the connection between our cultural inclination towards technology, the nature of technology itself, and birthing women's attitudes towards obstetrical technology using an analytical framework that includes literature on the philosophy of technology, as well as the sociology of childbirth. Data were gathered using a survey instrument and semi-structured interviews to contrast women's attitudes towards technology and experiences of childbirth in a large Canadian city: 25 women who planned a home birth assisted by a midwife and 25 low-risk women who planned a hospital birth. The results reveal that the total number of interventions the women experienced correlates in part to their attitudes towards technology: resistance to it on the part of home birthers and flexibility on the part of hospital birthers. Home birthers' resistance to technology stemmed from a consciousness of its overuse which blocks awareness of a sacred and authoritative "birthing force". Rather than rejecting technology, however, home birthers made conscious decisions about its appropriate use and relied upon access to a range of secondary technologies. **Kornelsen J. Essences and imperatives: an investigation of technology in childbirth.** **Soc Sci Med. 2005 Oct;61(7):1495-504.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=16005783&query_hl=1
Les facteurs démographiques tels que âge et lieu de vie influent sur le lieu de l'accouchement,	[1351] OBJECTIVES: In the Netherlands, approximately one-third of births are planned home births, mostly supervised by a midwife. The relationship between maternal demographic factors and home births supervised by midwives was

hôpital ou AAD.	examined. DESIGN: Cross-sectional study. Setting Dutch national perinatal registries of the year 2000. POPULATION: All women starting their pregnancy care under the supervision of a midwife, because these women have the possibility of having a planned home birth. METHODS: The possible groups of birth were as follows: planned home birth or short stay hospital birth, both under the supervision of a midwife, or hospital birth under the supervision of an obstetrician after referral from the midwife during pregnancy or birth. The studied demographic factors were maternal age, parity, ethnicity and degree of urbanisation. Probabilities of having a planned home birth were calculated for women with different demographic profiles. MAIN OUTCOME MEASURE: Place of birth. RESULTS: In all age groups, the planned home birth percentage in primiparous women was lower than in multiparous women (23.5%vs 42.8%). A low home birth percentage was observed in women younger than 25 years. Dutch and non-Dutch women showed almost similar percentages of obstetrician-supervised hospital births but large differences in percentage of planned home births (36.5%vs 17.3%). Fewer home births were observed in large cities (30.5%) compared with small cities (35.7%) and rural areas (35.8%). CONCLUSIONS: This study demonstrates a clear relationship between maternal demographic factors and the place of birth and type of caregiver and therefore the probability of a planned home birth. **Anthony S, Buitendijk SE, Offerhaus PM, Dommelen P, Pal-de Bruin KM. Maternal factors and the probability of a planned home birth.{Hollande} BJOG. 2005 Jun;112(6):748-53.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15924531&query_hl=1
	[1352] BACKGROUND: No accurate method, clinical or otherwise, currently exists to determine the onset of labor precisely. The objective of this study was to investigate what influences the duration of first stage labor in women with spontaneous labor and childbirth in a nonclinical setting. METHODS: From a population-based cohort of 1,448 planned home and birth center births, we selected 932 births for absence of pathology, absence of intervention, and completeness of data. Duration of first stage labor was analyzed with regression analysis for duration data or time-to-event analysis, using a specialized Transition Data Analysis software. The effects of fixed (age, parity, education, antenatal classes, infant birthweight, first cervical assessment) and time-varying factors (start of midwifery care, spontaneous rupture of membranes) in labor were

	estimated with piecewise-constant exponential hazard models. RESULTS: Of the characteristics immutable at the onset of labor, only parity had a strong effect on the duration of first stage labor. Cervical dilatation at first assessment and time-varying factors, such as the timing of spontaneous rupture of membranes and midwifery care, each had a strong influence on labor duration; however, the sequence in which they occurred exerted an even stronger influence. First stage labors were much shorter if the membranes ruptured before rather than after the start of care. CONCLUSION: With the exception of parity, events occurring during labor and their timing have a greater influence on the duration of first stage spontaneous labor than elements which are immutable at the onset of labor. Trials of interventions to influence the duration of labor need to consider not only whether the intervention was applied or not, but also when it was applied, if cause-effect relationships are to become properly understood. **Gross MM, Drobnic S, Keirse MJ. Influence of fixed and time-dependent factors on duration of normal first stage labor.** **Birth. 2005 Mar;32(1):27-33.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15725202&query_hl=1
	[1353] What is it? This question arose early this year during a discussion with my doula partner, who lived in Great Britain for 20 years, and one of the midwives I work with, who attends only homebirths, which is very rare in France. The mom whose case we were discussing was late going into labor but not postdated according to the official pregnancy term here in France (37-42 WA--"weeks of amenorrhea"). The midwife expressed her discomfort with waiting. My doula partner and I felt differently, but we knew we were influenced by American and British midwives' practices. I had been shocked the previous December by the position of the chief of the maternity department in a private hospital (a small unit with no residents, in which nurse-midwives attend "normal" births and obstetricians are called in case of complications only). This OB explained to my client and me that if she didn't go into labor naturally, she would be called at 41 + 1 for a vaginal exam to check her cervix and would be induced at 41 + 2. Waiting until 42 weeks requires daily checks, for which he has neither the room nor personnel. He clearly stated that it was a matter of management of time and finances. A month later one of our clients reported the story of her brother and sister-in-law's planned homebirth in London. Their doctors had put a lot of pressure on the mother during her pregnancy with gestational

	diabetes regarding her length of term. They started to talk about induction. The parents didn't feel comfortable with this, and at that point our client had asked me to refer them to someone who could help them there. We referred them to the National Childbirth Trust and to the sweetest doula we know there. This doula (Liliana Lammers) and her famous doctor partner (Dr. Michel Odent) were a good match. The doctor advised waiting, on the condition that the health of the baby and the amount of fluid be checked daily at the local hospital. The mother had already been waiting several weeks past what was supposed to be her term. Finally, she went naturally into labor at home. The doctor and the doula came and, after some hours of observation, decided it would be wiser for the mother to deliver in the hospital. The doctor and doula were not comfortable with the prolonged prelabor, when, at nearly 44 weeks, the health of the baby and the amount of fluid had not been checked for five days. The mother finally had a vaginal birth without drugs at the hospital. After hearing this story, I suggested it would be interesting to collect the official lengths of term and the different routines in other countries as a learning tool and in order to give us something other than French protocol on which to base our practice. So I sent the question to every midwife for whom I had an e-mail address from the last Midwifery Today conference in Paris. Beyond this motivation was my own curiosity regarding the relationship between the official term in each country and its uses and routines. The most significant (because the most unique) answer, in my opinion, is from The Netherlands, where physiology is a priority. **Dubreuil VL. Standard term of pregnancy. Midwifery Today Int Midwife. 2004 Winter;(72):51-3.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15651459&query_hl=1
Synthèse des études randomisées maisons de naissance versus hôpital. Peu de valeur car la randomisation en elle-même introduit un biais majeur, le déni du choix du lieu d'accouchement.	[1362] BACKGROUND: Home-like birth settings have been established in or near conventional labour wards for the care of pregnant women who prefer and require little or no medical intervention during labour and birth. OBJECTIVES: Primary: to assess the effects of care in a home-like birth environment compared to care in a conventional labour ward. Secondary: to determine if the effects of birth settings are influenced by staffing or organizational models or geographical location of the birth centre. SEARCH STRATEGY: We searched the Cochrane Pregnancy and Childbirth Group trials register (18 May 2004) and handsearched eight journals and two published conference proceedings. SELECTION CRITERIA: All randomized or quasi-randomized controlled trials that compared the

	effects of a home-like institutional birth environment to conventional hospital care. DATA COLLECTION AND ANALYSIS: Standard methods of the Cochrane Collaboration Pregnancy and Childbirth Group were used. Two review authors evaluated methodological quality. Double data entry was performed. Results are presented using relative risks and 95% confidence intervals. MAIN RESULTS: Six trials involving 8677 women were included. No trials of freestanding birth centres were found. Between 29% and 67% of women allocated to home-like settings were transferred to standard care before or during labour. Allocation to a home-like setting significantly increased the likelihood of: no intrapartum analgesia/anaesthesia (four trials; n = 6703; relative risk (RR) 1.19, 95% confidence interval (CI) 1.01 to 1.40), spontaneous vaginal birth (five trials; n = 8529; RR 1.03, 95% CI 1.01 to 1.06), vaginal/perineal tears (four trials; n = 8415; RR 1.08, 95% CI 1.03 to 1.13), preference for the same setting the next time (one trial; n = 1230; RR 1.81, 95% CI 1.65 to 1.98), satisfaction with intrapartum care (one trial; n = 2844; RR 1.14, 95% CI 1.07 to 1.21), and breastfeeding initiation (two trials; n = 1431; RR 1.05, 95% CI 1.02 to 1.09) and continuation to six to eight weeks (two trials; n = 1431; RR 1.06, 95% CI 1.02 to 1.10). Allocation to a home-like setting decreased the likelihood of episiotomy (five trials; n = 8529; RR 0.85, 95% CI 0.74 to 0.99). There was a trend towards higher perinatal mortality in the home-like setting (five trials; n = 8529; RR 1.83, 95% CI 0.99 to 3.38). No firm conclusions could be drawn regarding the effects of staffing or organizational models. AUTHORS' CONCLUSIONS: When compared to conventional institutional settings, home-like settings for childbirth are associated with modest benefits, including reduced medical interventions and increased maternal satisfaction. Caregivers and clients should be vigilant for signs of complications. **Hodnett ED, Downe S, Edwards N, Walsh D. Cochrane Database Syst Rev. 2005 Jan 25;(1):CD000012. (Update of Cochrane Database Syst Rev. 2001;(4):CD000012.).** **Home-like versus conventional institutional settings for birth.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15674867&query_hl=2 Remarques : Texte en accès libre.
	[581] read the recent commentary by Hannah (1) with great interest. The author states in the

	conclusion that "if a woman without an accepted medical indication requests delivery by elective caesarean section and, after a thorough discussion about the risks and benefits, continues to perceive that the benefits to her and her child of a planned elective caesarean outweigh the risks, then most likely the overall health and welfare of the woman will be promoted by supporting her request". It is very important that all evidence on the benefits and harms are presented to the prospective mother. In the UK the National Institute of Clinical Excellence (NICE) is part of the National Health Service (NHS), and its role is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current "best practice" (2). Currently NICE is in the process of producing clinical guidelines on Caesarean section (CS), which is expected to be released in April this year. However, the second draft of the guideline is available on line (3). According to the draft document (3) "maternal request is not on it's own an indication for CS" and the document adds that "pregnant women should be supported in whatever decision is made following these discussions" (page 27). The document provides current evidence on length of stay, abdominal pain, perineal pain, postpartum haemorrhage, infection, breastfeeding, bladder and urinary tract injuries, need for further surgery, risk of thromboembolic disease and many other clinical outcomes and majority of these favour vaginal birth compared to CS (pages 19-21). Women should have a right to exercise their choice on the mode of delivery even when there are no clinical indications for CS. However providing this procedure to these women in a publicly funded system such as the NHS would increase the overall cost and the opportunity cost thus incurred might deny services that would be of benefit to other users of the service. **Lindballe PL. Patient choice should be universal. Letter.** **CMAJ 2004;170:858.** http://www.cmaj.ca/cgi/eletters/170/5/813#858
	[681] Objective: to develop an intrapartum intervention scoring tool which could be used to define maternity units as either `lower intrapartum intervention' or `higher intrapartum intervention' units. This scoring tool was designed to form the basis of a comparison of the perception of risk by midwives working in either `lower intrapartum intervention' or `higher

	intrapartum intervention' units. Design: three aspects were included: (1) the systematic data reduction of the St. Mary's Maternity Information System database used by 11 maternity units to include Caucasian nulliparous women suitable for midwifery-led care; (2) the calculation and the ranking of frequency distributions for the following interventions/management: (a) the management of breech presentation and of one previous caesarean section, the choice of home birth; and (b) augmentation of labour, use of electronic fetal monitoring, use of epidural, method of delivery; (3) the sum of the individual intrapartum ranking marks made up the final intrapartum score for each unit. Results: intrapartum interventions varied considerably between units. The scoring system enabled units to be described as either `Lower intrapartum intervention' or `Higher intrapartum intervention' units. Conclusions: routinely collected computerised data can be used to identify the outcomes of intrapartum care. This study suggests that the analysis of computerised data could provide a suitable basis for the audit and the comparison of intrapartum interventions for the care of women suitable for midwifery-led care. **Mead M, Kornbrot D. An intrapartum intervention scoring system for the comparison of maternity units' intrapartum care of nulliparous women suitable for midwifery-led care. Midwifery 2004;20(1):15-26.** http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6WN9-4BWC77H-2&_user=10&_handle=B-WA-A-A-AB-MsSAYZA-UUA-AUYVEVEEDU-AUYWCBUDDU-BZDWEZVWE-AB-U&_fmt=summary&_coverDate=03%2F31%2F2004&_rdoc=3&_orig=browse&_srch=%23toc%236957%232004%23999799998%23484600!&_cdi=6957&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=a90cd976c05de317f0cc4a9197fe73a8 Remarques : Texte en accès libre.
Il existe une distinction fondamentale entre accouchement vaginal	[834] Le débat actuel entourant la possibilité pour les femmes d'obtenir de leur obstétricien une césarienne sur demande a fait l'objet d'un article paru dans votre journal en mars 2004. Dans cet

(c'est-à-dire naissance par les voies naturelles) et accouchement physiologique (expression d'un processus physiologique normal non perturbé).	article, Hannah nous informe du fait que seule une nouvelle étude randomisée contrôlée pourrait permettre d'évaluer les risques et les avantages d'une césarienne programmée par opposition à un accouchement vaginal planifié. Afin d'illustrer certains avantages de la césarienne élective, Hannah introduit plusieurs résultats statistiques reliés en particulier aux taux d'incontinence urinaire. Or, dans cet article, le terme d'accouchement vaginal spontané mériterait d'être mieux défini. Quand Hannah fait référence au taux d'incontinence urinaire suivant un accouchement vaginal spontané, on est en droit de se demander, par exemple, si dans l'étude citée les femmes mettant au monde leur bébé ont fait l'expérience d'une poussée physiologique involontaire, non dirigée, faisant intervenir le réflexe de poussée. Ou plutôt, s'il s'est agit d'un accouchement vaginal spontané, sous péridurale par exemple, durant lequel à dilatation complète la femme s'est vu encouragée à inspirer, bloquer, pousser. Les résultats et les conséquences sur le périnée féminin sont-ils les mêmes d'une manière ou de l'autre? Ceci nous amène à questionner l'autorité que l'on doit accorder à Hannah dès lors qu'elle fait référence à la notion d'accouchement vaginal spontané. Lorsqu'on parle de spontané cela veut dire que l'accouchement s'est déroulé spontanément, c'est-à-dire physiologiquement. Si c'est le cas, l'induction, la stimulation, le monitoring, la restriction des positions pour la poussée, la péridurale, le «coaching» de la poussée, l'épisiotomie, les ventouses, les pressions abdominales, les forceps, seraient tous des éléments qui excluraient ces accouchements de la catégorie accouchement vaginal spontané. Il est évident pour ceux qui en ont été témoins qu'il existe une distinction fondamentale entre accouchement vaginal (c'est-à-dire naissance par les voies naturelles) et accouchement physiologique (expression d'un processus physiologique normal non perturbé). Le milieu hospitalier est reconnu comme un milieu où les comportements sont fortement codifiés et structurés. Une femme qui y accouche aujourd'hui ne devrait trop espérer y être soutenue dans sa «spontanéité». L'accouchement vaginal spontané observé en milieu hospitalier comporte un biais énorme, celui-là même d'avoir lieu dans un espace, l'hôpital, où le processus physiologique normal de la mise au monde d'un bébé est quasiment toujours perturbé. L'hôpital est un biais systématique important introduit dans toutes les études sur l'accouchement, sans jamais être mentionné comme une des limites des études.

	L'accouchement vaginal spontané devrait être clairement défini dans les futures études scientifiques, incluant celles dirigées par Hannah. Si l'on souhaite vraiment comparer les césariennes sur demande avec l'accouchement vaginal spontané, on devrait le faire en se concentrant sur l'espace le plus propice à un accouchement spontané et physiologique, c'est-à-dire l'accouchement à la maison. **Gerbelli C. Elective cesarean section. Letters. Canadian Medical Association Journal 2004;171(1):15.** http://www.cmaj.ca/cgi/content/full/171/1/15?etoc Remarques : Voir version PDF: http://www.cmaj.ca/cgi/reprint/171/1/15-a.pdf
L'accouchement vaginal spontané observé en milieu hospitalier comporte un biais énorme, celui-là même d'avoir lieu dans un espace, l'hôpital, où le processus physiologique normal de la mise au monde d'un bébé est quasiment toujours perturbé.	[838] Elective cesarean section Catherine Gerbelli Sage-femme, AFAR Québec (Alliance francophone pour l'accouchement respecté), Montréal, Que. Le débat actuel entourant la possibilité pour les femmes d'obtenir de leur obstétricien une césarienne sur demande a fait l'objet d'un article paru dans votre journal en mars 2004[1]. Dans cet article, Hannah nous informe du fait que seule une nouvelle étude randomisée contrôlée pourrait permettre d'évaluer les risques et les avantages d'une césarienne programmée par opposition à un accouchement vaginal planifié. Afin d'illustrer certains avantages de la césarienne élective, Hannah introduit plusieurs résultats statistiques reliés en particulier aux taux d'incontinence urinaire. Or, dans cet article, le terme d'accouchement vaginal spontané mériterait d'être mieux défini. Quand Hannah fait référence au taux d'incontinence urinaire suivant un accouchement vaginal spontané, on est en droit de se demander, par exemple, si dans l'étude citée les femmes mettant au monde leur bébé ont fait l'expérience d'une poussée physiologique involontaire, non dirigée, faisant intervenir le réflexe de poussée. Ou plutôt, s'il s'est agit d'un accouchement vaginal spontané, sous péridurale par exemple, durant lequel à dilatation complète la femme s'est vu encouragée à inspirer, bloquer, pousser. Les résultats et les conséquences sur le périnée féminin sont-ils les mêmes d'une manière ou de l'autre? Ceci nous amène à questionner l'autorité que l'on

	doit accorder à Hannah dès lors qu'elle fait référence à la notion d'accouchement vaginal spontané. Lorsqu'on parle de spontané cela veut dire que l'accouchement s'est déroulé spontanément, c'est-à-dire physiologiquement. Si c'est le cas, l'induction, la stimulation, le monitoring, la restriction des positions pour la poussée, la péridurale, le «coaching» de la poussée, l'épisiotomie, les ventouses, les pressions abdominales, les forceps, seraient tous des éléments qui excluraient ces accouchements de la catégorie accouchement vaginal spontané. Il est évident pour ceux qui en ont été témoins qu'il existe une distinction fondamentale entre accouchement vaginal (c'est-à-dire naissance par les voies naturelles) et accouchement physiologique (expression d'un processus physiologique normal non perturbé). Le milieu hospitalier est reconnu comme un milieu où les comportements sont fortement codifiés et structurés. Une femme qui y accouche aujourd'hui ne devrait trop espérer y être soutenue dans sa «spontanéité». L'accouchement vaginal spontané observé en milieu hospitalier comporte un biais énorme, celui-là même d'avoir lieu dans un espace, l'hôpital, où le processus physiologique normal de la mise au monde d'un bébé est quasiment toujours perturbé. L'hôpital est un biais systématique important introduit dans toutes les études sur l'accouchement, sans jamais être mentionné comme une des limites des études. L'accouchement vaginal spontané devrait être clairement défini dans les futures études scientifiques, incluant celles dirigées par Hannah. Si l'on souhaite vraiment comparer les césariennes sur demande avec l'accouchement vaginal spontané, on devrait le faire en se concentrant sur l'espace le plus propice à un accouchement spontané et physiologique, c'est-à-dire l'accouchement à la maison. Catherine Gerbelli, Sage-femme AFAR Québec (Alliance francophone pour l'accouchement respecté) Montréal, Que. Référence 1. Hannah ME. Planned elective cesarean section: A reasonable choice for some women? [editorial]. CMAJ 2004;170(5):813-4. **Catherine Gerbelli. Qu'est-ce qu'un accouchement spontané? Lettre à l'éditeur, à propos de Planned elective cesarean section: A reasonable choice for some women? [editorial]. Hannah ME, CMAJ 2004;170(5):813-4.**

	http://www.cmaj.ca/cgi/content/full/171/1/15
	[932] OBJECTIVES: To compare the efficacy of a single 100 micro g intramuscular (IM) carbetocin injection, a long-acting oxytocin agonist, to a 2-hour 10 IU oxytocin intravenous (IV) infusion, in reducing the incidence and severity of postpartum hemorrhage (PPH) in women at risk for this condition. METHODS: A randomized, double-blind, placebo-controlled study was conducted at 2 hospital centres, including 160 women with at least 1 risk factor for PPH. Eighty-three women received 100 microg carbetocin IM and an IV placebo immediately after placental delivery, while 77 women received placebo IM and oxytocin IV infusion. Complete blood count was collected at entry and 24 hours postpartum. All outcome measures, including the need for additional uterotonic agents or uterine massage, blood loss, and drop in hemoglobin and hematocrit, were analyzed using chi-square, Fisher exact, and Student t tests. RESULTS: Population profile and risk factors for PPH were similar for each group. No significant difference was observed in the number of women requiring additional uterotonic medication (12 in each group). However, in the carbetocin group, 36 of the 83 women (43.4%) required at least 1 uterine massage compared to 48 of the 77 women (62.3%) in the oxytocin group (P <.02). Overall, uterotonic intervention was clinically indicated in 37 of the women (44.6%) receiving carbetocin compared to 49 of the women (63.6%) given an IV oxytocin infusion (P <.02). There were no differences in laboratory PPH indicators between the 2 groups. **Boucher M, Nimrod CA, Tawagi GF, Meeker TA, Rennicks White RE, Varin J. Comparison of carbetocin and oxytocin for the prevention of postpartum hemorrhage following vaginal delivery:a double-blind randomized trial.** **J Obstet Gynaecol Can. 2004 May;26(5):481-8.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15151735
	[1354] BACKGROUND: A home confinement with midwifery care is still an integral part of Dutch maternity care. It has been argued that the existence of home birth itself influences the course of the birth process positively, which is why obstetric interventions are low in comparison with neighboring countries. This study examined the impact of women's intended place of birth (home or hospital) and the course of pregnancy and labor when attended by midwives. METHODS: This is a prospective study of 625 low-

	risk pregnant women, gestation 20 to 24 weeks, enrolled in 25 independently working midwifery practices. The course of labor was measured by the frequency of interventions by midwives and obstetricians. RESULTS: A more non-technological approach to childbirth was observed within the women opting for a home birth compared with the women opting for a hospital birth. Data showed a relationship between interventions and planned birth site: sweeping membranes and amniotomy by midwives were more likely to be conducted in women opting for a home birth. Multiparas opting for hospital birth were more likely to experience consultations and referrals. Within the group of multiparas referred for obstetrician care, women intending to have a home birth experienced fewer interventions (e.g., induction, augmentation, pharmacologic pain relief, assisted delivery, cesarean section) compared with those who had opted for a hospital birth. CONCLUSIONS: A large proportion of women desire a home birth. The impact of that choice demonstrated a smoother course of the birth process, compared with women who desired to deliver in the hospital, as measured by fewer obstetric interventions. We suggest that psychological factors (expectation and perceptions) influence both a woman's decision of birthplace and the actual birth process. **van Der Hulst LA, van Teijlingen ER, Bonsel GJ, Eskes M, Bleker OP. Does a pregnant woman's intended place of birth influence her attitudes toward and occurrence of obstetric interventions? {Hollande}.** **Birth. 2004 Mar;31(1):28-33.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15015990&query_hl=1
Sécurité des maisons de naissance indépendantes, UK: très variable d'un lieu à un autre.	[1363] BACKGROUND: Over the last two decades, childbirth worldwide has been increasingly concentrated in large centralized hospitals, with a parallel trend toward more birth interventions. At the same time in several countries, interest in midwife-led care and free-standing birth centers has steadily increased. The objective of this review is to establish the current evidence base for free-standing, midwife-led birth centers. METHODS: A structured review, based on Cochrane guidelines, was conducted that included nonrandomized studies. The comparative outcomes measured were rates of normal vaginal birth; cesarean section; intact perineum; episiotomy; transfers; and babies remaining with their mothers. RESULTS: Of the 5 controlled studies that met the review criteria, all except one was a single site

	study. Since no study was randomized, meta-analysis was not performed. The included studies all raised quality concerns, and significant heterogeneity was observed among them. For the outcomes measured, every study reported a benefit for women intending to give birth in the free-standing, midwife-led unit. CONCLUSIONS: The benefits shown for women recruited into the included studies who intended to give birth in a free-standing, midwife-led unit suggest a question about the efficacy of consultant unit care for low-risk women. However, the findings cannot be generalized beyond the individual studies. Good quality controlled studies are needed to investigate these issues in the future. **Walsh D, Downe SM. Outcomes of free-standing, midwife-led birth centers: a structured review. Birth. 2004 Sep;31(3):222-9.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15330886&query_hl=2
Revue des données périnatales des maisons de naissance en Bavière et à Berlin.	[1364] QUESTION: The purpose of this investigation is to find any differences between important maternal and infantile perinatal data from a clinic and a birth center group. Is the perinatal and/or maternal mortality in the birth center group higher? What influence do different socioeconomic factors have on the clinic group? PATIENTS AND METHODS: We have carried out a retrospective comparison of the obstetric parameters from all birth center deliveries in the states Berlin and Bavaria for the years 1999 and 2000 (n = 3,060) and the perinatal data investigations of selected clinical groups of both states (n = 55,875). RESULTS: Objective parameters in both groups regarding week of potation at delivery, parity, age of pregnant women, infantile measures, primi- and multiparae and Apgar scales were comparable. There are significant differences in the delivery mode (spontaneous deliveries: birth centers > clinics; operative deliveries: birth centers < clinics), in blood loss over 1,000 ml (birth centers > clinics), in the episiotomy and perineal tear rate (birth centers < clinics), in the infantile transfer rate to a neonatology unit (birth centers < clinics) and in the frequency of necessary neonatological measures in the neonate (birth centers > clinics). The perinatal and maternal mortality in the groups were similar. Within the clinical group the socioeconomic status and a background of immigration had no significant influence on the perinatal data. CONCLUSION: The retrospective data show that the more "invasive" clinical obstetrics leads to a similar postnatal condition of the neonates in comparison to the birth house group. Further comparative studies over several years are necessary to make statements about the occurrence

	of rare risks and maternal mortality in the free-standing birth center groups. **David M, Pachaly J, Vetter K, Kentenich H. [Birthplace free-standing birth center -- perinatal data in comparison with clinic deliveries in Bavaria and Berlin] [Article in German]. Z Geburtshilfe Neonatol. 2004 Jun;208(3):110-7.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15229818&query_hl=2
	[1365] This study aimed to evaluate the safety of this birth setting for low-risk deliveries based on our hospital protocol. The study was carried out at Heatherwood Hospital, Ascot (a low-risk unit) and Wexham Park Hospital, Slough, Berkshire (a consultant-led unit). This was a retrospective analysis of the computerised records and statistics of low-risk women delivered at Heatherwood Hospital, Ascot, UK following the unit protocol between July 1995 and December 2001. Women were assessed to be at low risk in accord with the unit protocol. Those who had antenatal and intrapartum care at Heatherwood Hospital and those who were transferred to the consultant unit for delivery were included in this study. We analysed the appropriateness of the structure of the unit with its medical staff input, reviewed the inclusion and exclusion criteria, analysed the perinatal and maternal mortality rates and evaluated the safety of this birth setting. We have had a total of 5468 women delivered at this low-risk maternity unit since the unit was opened. Approximately 1950 women were transferred to consultant care during this period. The intrapartum transfer in the first 18 months was 7.9%. However, since 1997 it has been static at 2.7% as confidence has grown in this model of care. The antenatal transfer rate has been static around 23%. Our emergency caesarean section rate was around 6% and the normal delivery rate was around 85%. For the first time we noted a rise in the emergency caesarean rate in 2001 at 9.5%. There were no maternal deaths. We had no serious postpartum complications accounting for long-term maternal morbidity. The antepartum stillbirths accounted for the majority of the perinatal mortality for 19/23 babies. Intrauterine growth retardation accounted for 4/23 babies in this group. The perinatal mortality rate in this low-risk population was 4.2 per 1000 total births and the stillbirth rate was 3.6 per 1000 total births. We conclude that this birth setting is safe to deliver low-risk women with less intrapartum intervention and a low transfer rate and should be setting an example for any future similar birth centre in this country.

	Reddy K, Reginald PW, Spring JE, Nunn L, Mishra N. A free-standing low-risk maternity unit in the United Kingdom: does it have a role? J Obstet Gynaecol. 2004 Jun;24(4):360-6. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15203571&query_hl=2
	[1366] OBJECTIVE: To study perinatal mortality in women booked for birth centre care during pregnancy. DESIGN: Retrospective cohort study. SETTING: In-hospital birth centre and standard maternity care in Stockholm. POPULATION: Two thousand and five hundred and thirty-four women (3256 pregnancies) admitted to an in-hospital birth centre over 10 years (1989-2000) and 126818 women (180380 pregnancies) who gave birth in standard care during the same period and who met the same medical inclusion criteria as in the birth centre. Multiple pregnancies were excluded. METHODS: Data were collected from the Swedish Medical Birth Register. Information on all cases of perinatal death in the birth centre group was retrieved from the medical records. MAIN OUTCOME MEASURE: Perinatal mortality. RESULTS: No statistically significant difference in the overall perinatal mortality rate was observed between the birth centre group and the standard care group (odds ratio [OR] 1.5, 95% CI 0.9-2.4), but infants of primiparas were at greater risk (OR 2.2, 95% CI 1.3-3.9). Infants of multiparas tended to be at lower risk, but this difference was not statistically significant (OR 0.7, 95% CI 0.3-1.9). These figures were adjusted for maternal age and gestation in multiple regression analyses. CONCLUSION: Birth centre care may be less safe for infants of first-time mothers. **Gottvall K, Grunewald C, Waldenstrom U. Safety of birth centre care: perinatal mortality over a 10-year period. {Suède}. BJOG. 2004 Jan;111(1):71-8.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=14687055&query_hl=2
	[13] Est-il judicieux d'accoucher à domicile? Quelques indications pour vous aider à prendre une décision. L'auteur précise dans quelles conditions les accouchements à domicile peuvent être planifiés dans les différentes provinces du Canada. On apprend par exemple que les sages-femmes qui accompagnent des AAD en Colombie Britannique, Manitoba et Ontario, sont entièrement rémunérées par l'Etat, alors qu'elles n'ont pas le droit d'accompagner les AAD dans la province du Québec…

	Accoucher à la maison Devez-vous accoucher dans votre « tanière » ? Voici des informations pour faire votre choix ! par Bonny Reichert A lire en anglais : The Birth Organizer Alors, est-ce sans danger d'accoucher à la maison ? Cela dépend de la personne à laquelle on demande. Parce que la naissance a longtemps été considérée comme un événement médical dans notre société, les « profanes » ont tendance à supposer que c'est dangereux. Et ce sentiment ne vient pas de nulle part. Bien que la Société des Obstétriciens et des Gynécologues du Canada soutienne l'action des sages-femmes pour les grossesses sans complication, leur politique officielle précise : « La SOGC est opposée à l'accouchement à la maison car il comporte des risques potentiels pour la mère et le fœtus ». Quels sont les risques ? J'ai contacté la SOGC pour le découvrir, mais leur département des relations publiques n'a pas trouvé de médecin désirant être interviewé à propos de l'accouchement à domicile. Cependant, une étude publiée dans le numéro de Février 2002 du Journal de l'Association Médicale Canadienne a découvert que les accouchements à domicile prévus et auxquels assiste une sage-femme de métier reconnue, n'est pas plus dangereux qu'un accouchement à l'hôpital, pour les mamans et les bébés. La recherche, basée sur plus de 2100 naissances de Colombie Britannique, a été préparée par une équipe d'experts (comprenant Patricia Janssen du département de family practice à l'Université de Colombie Britannique et Micheal Klein, un médecin généraliste de Colombie Britannique) et financé par Canada Santé. Patricia Mc Niven, sage-femme reconnue depuis presque 20 ans, qui enseigne en quatrième année des études de sage-femme à l'Université de McMaster à Hamilton, est d'accord avec cette affirmation. Elle précise : « Les complications les plus communes à la naissance sont l'hémorragie de la mère et le stress fœtal - la difficulté à respirer pour le bébé - et nous amenons avec nous tout le matériel nécessaire à la gestion de ces problèmes ». Un autre problème de sécurité des plus importants : savoir quand le transfert à l'hôpital est nécessaire, ou du moins en avoir une bonne idée. « Nous essayons d'effectuer le transfert avant que cela soit urgent, c'est ce qui garantit la

	sécurité. Si vous trouvez une anomalie dans le rythme de cœur du bébé ou du méconium (selle du bébé- signe de stress foetal) dans l'eau, vous partez ! » Bien que les urgences arrivent, il est important de les replacer dans le contexte : « La recherche de l'Ontario montre que la raison de transfert à l'hôpital la plus fréquente est le soulagement de la douleur ; ensuite c'est la lenteur du processus d'accouchement, » mentionne Mc Niven. Ces deux raisons de transfert sont légitimes mais elles ne représentent pas des urgences ! Il existe même des recherches qui mentionnent que l'accouchement à la maison peut être bon pour la mère et l'enfant. Un projet dirigé par l'Université de Copenhague en 1997 s'intéresse à six études contrôlées couvrant 24000 femmes dont l'accouchement était considéré à faibles risques, et qui prévoyaient un accouchement à domicile. Quand les chercheurs ont comparé les résultats, ils ont trouvé des taux de mortalité très peu différents entre accouchement à la maison et à l'hôpital. Cependant, les accouchements à la maison avaient des taux de APGAR plus bas et moins de lacérations maternelles (épisiotomie et déchirements). Il y avait moins d'interventions médicales dans ce groupe également : moins d'accouchements provoqués, d'épisiotomies, de césariennes et de délivrances assistées. Qu'est-ce qui est si bien dans l'accouchement à la maison ? Pour certains parents, les bénéfices de l'accouchement à domicile sont évidents : vous êtes dans un environnement familier et privé, qui est plus confortable et plus approprié qu'un hôpital, sans compter qu'il vous donne plus de pouvoir. Quand vous êtes chez vous, personne n'insiste pour que vous portiez un vêtement quelconque, pour que vous enleviez vos bagues, ou que vous restiez dans votre chambre. De plus votre accouchement peut être aussi public ou aussi privé que vous le désirez. Vous pouvez vous entourer d'amis, de famille, et même de vos enfants plus âgés, si telle est votre préférence. Vous pouvez aussi choisir de n'inviter personne et ne rester qu'avec la personne qui vous accompagne. Une naissance à la maison signifie aussi ne pas avoir à courir pour aller et revenir de l'hôpital (les femmes qui accouchent avec des sages-femmes sont souvent « libérées » quelques heures après la

	naissance - à moins qu'il y ait eu des complications - puisque elles doivent assurer le suivi postpartum de la grossesse à la maison). Ainsi, il n'y pas d'anxiété liée à l'arrivée en avance ou en retard à l'hôpital. L'attention que vous portez à une naissance à la maison est aussi unique : c'est juste une situation extrêmement personnelle vécue à deux ou à trois sans rotation de personnel hospitalier. Sans compter les heures passées avec la sage-femme pendant les réunions prénatales (qui durent environ 45 mn ou 1 heure) qui vous donnent un suivi et une attention complets. Qu'est-ce qui est moins bien dans l'accouchement à la maison ? Clairement, l'accouchement à la maison n'est pas pour tout le monde. Les femmes qui portent des jumeaux (ou des triplés), qui commencent le travail avant 37 semaines de grossesse et dont les bébés se présentent par le siège sont parmi celles qui accoucheront mieux à l'hôpital. Les sages-femmes sont entraînées à reconnaître les autres problèmes médicaux pendant la grossesse et peuvent décider de refuser que l'accouchement se passe à la maison quand cela n'est pas approprié à la situation de la femme. L'accouchement à domicile ne convient pas à toutes les femmes dont la grossesse présente de faibles risques de complications, non plus. Le fait de se sentir plus en sécurité et mieux tout simplement dans un hôpital est un excellente raison pour y accoucher. « De nos jours, on peut vivre une fabuleuse naissance naturelle à l'hôpital », selon McNiven (voir "How to Bring a Little Bit of Home to the Hospital" p.76). Quand on donne naissance à l'hôpital, on n'a pas à s'inquiéter de faire les courses ni de faire le ménage. Si vous préférez que votre jeune enfant ne voie pas ce qui se passe vous pouvez le laisser à un membre de la famille ou à une baby-sitter à la maison. Et si vous pensez que vous allez vouloir une péridurale ou tout autre soulagement de la douleur, l'hôpital est pour vous. Est-ce autorisé partout au Canada et combien ça coûte ? Il se peut que vous ayez entendu parler du médecin de famille qui assiste un accouchement à la maison, mais en général, si vous projetez d'accoucher à la maison il vous faudra trouver une sage-femme. En Colombie Britannique, au Manitoba et en Ontario, les sages-femmes sont reconnues et sont autorisées

	à assister une femme accouchant à la maison ou à l'hôpital. Dans tous les cas, leurs services sont complètement financés par le département. Un accouchement ayant lieu dans une de ces trois villes ne coûte pas plus qu'un sac poubelle vert, un paquet de gazes stériles, quelques alaises et autres petites choses que votre sage-femme vous demandera d'avoir à portée de main. En Alberta, les sages-femmes assistent les accouchements à la maison et certains accouchements à l'hôpital (cela dépend de la ville), elles sont reconnues par le département et payées par les parents. Selon Patty Lenstra, enregistrée à l'association de sages-femme d'Alberta : « Chaque sage-femme définit sa commission, mais la plupart d'entre elles comptent environ 2500 dollars canadiens pour le suivi complet (suivi prénatal, travail, niassance et post-accouchement – 6 semaines environ). La législation du Québec ne permet actuellement pas aux sages-femmes d'assister des accouchements à la maison. A New Brunswick, Nova Scotia, l'Ile du Prince Edouard et à Newfoundland, les sages-femmes assistent les accouchements à domicile, mais ne sont pas règlementées par le gouvernement provincial. Elles sont rémunérées par les familles. Dans le Nord, il existe peu de sages-femmes et elles sont également payées par les parents. Qu'est-ce qu'une doula ? Si un médecin ou un gynécologue obstétricien s'occupe de vous, une doula peut ajouter une dimension toute autre à votre accouchement. Comme le précise Maryanne Zuzak, doula certifiée : « Au fond, une doula est là pour materner la mère, elle aide à la naissance en apportant un soutien émotionnel, physique et informationel. » Mme Zuzak demande 350 dollars canadiens pour ses services pendant la grossesse jusqu'à 6 semaines après l'accouchement, mais les taux varient. Comme la sage-femme, la doula vient chez vous au début du travail pour vous soutenir. Et, bien qu'elle ne fasse pas d'examens vaginaux, Mme Zuzak dit qu'une doula expérimentée saura quand le moment d'aller à l'hôpital est venu : « Nous pouvons le dire en observant les signes extérieurs – les sons que la femme produit, les choses qu'elle fait ou non… Si elle frappe le sol avec ses mains et ses genoux pendant les contractions c'est probablement le moment d'y aller ! » **Reichert, Bonny. Home Delivery**

	http://www.todaysparent.com/pregnancybirth/labour/article.jsp?content=1009255
	[614] Review by Churchill R, Journal of Midwifery & Women's Health 2004;49(2):165 Mavis Kirkham, Professor of Midwifery at the University of Sheffield, UK, has written an interesting survey of British and international birth centers. Birth Centres: A Social Model for Maternity Care is a collection of essays detailing the existence of freestanding birth centers in England and throughout the world. Her book provides the reader with a sense of what it takes to set up a birth center, the qualifications birth center midwives need to have, which types of collaborative relationships make for successful birth centers, and the parameters a client must meet in order to be considered a candidate for a birth center birth. While her intended audience is no doubt the British midwife or midwifery student, she presents much information that is of interest to the American midwife as well. The book is organized into three sections. The first discusses several of the 55 birth centers in England. The second is a case study of one of these centers, The Edgeware Birth Centre. The final section provides a look at birth centers around the world, reflecting both the different cultural backgrounds and environmental factors affecting the existence and survival of birth centers in each country. http://www2.us.elsevierhealth.com/scripts/om.dll/serve?action=searchDB&searchDBfor=art&artType=fullfree&id=as1526952304000157 **Kirkham M. Birth Centres: a Social Model for Maternity Care.** **London: Elsevier Science Limited, 2003.**
	[1083] A House of Commons committee has criticised UK maternity services as patchy and has urged more trusts to support women who want to give birth at home. The health select committee published two reports last week, one on inequality in access to maternity services across the United Kingdom and one on choice in maternity services. The second report urged healthcare trusts to support the option of home births and to provide independent midwives where needed. The committee estimates that up to 10 times as many women would want to give birth at home, if given the choice, but that this choice was either not provided or taken away.

	In its report on access to maternity services the committee says that not all families across the country are getting access to the services that they need. The report identifies prejudice among maternity care staff relating to race, class, or disability. The Royal College of Midwives admitted to institution-alised racism in the maternity services. The committee recommends that trusts recruit midwives from a greater range of ethnic groups and communities to redress the imbalance. In particular the report highlights the problems faced by homeless women, asylum seekers, women whose first language is not English, and deaf women. **Tayal, Upsana. Commons committee calls for more choice over home births. BMJ 2003;327:249 (2 August), doi:10.1136/bmj.327.7409.249** http://bmj.bmjjournals.com/cgi/content/abridged/327/7409/249
	[1355] Midwifery emerged as a self-regulated profession in British Columbia in the context of a 2-year demonstration project beginning in 1998. The project evaluated accountability among midwives, defined as the provision of safe and appropriate care and maintenance of standards of communication set by the College of Midwives of British Columbia. Adherence to protocols was measured by using documentation designed specifically for the Home Birth Demonstration Project. Hospital and transport records for selected clients were reviewed by an expert committee. Outcomes among Home Birth Demonstration Project clients were compared with outcomes among women eligible for home birth but planning to deliver in hospital. Adherence to clinical and communication protocols was 96% or higher. Planned home birth was not associated with an increase in risk but prevalence of adverse outcomes was too low to be studied with precision. Recommendations of an expert review committee have been implemented or are under review. Midwives have demonstrated a high degree of compliance with reporting requirements and protocols. Comparisons of birth outcomes of planned home versus hospital births, while supporting home birth as a choice for women, were limited in scope and require ongoing study. Integration of home birth has been a dynamic process with guidelines and policy continuing to evolve. **Janssen PA, Lee SK, Ryan ER, Saxell L. An evaluation of process and protocols for planned home birth attended by regulated midwives in**

	British Columbia. **J Midwifery Womens Health. 2003 Mar-Apr;48(2):138-45.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=12686947&query_hl=1
	[945] OBJECTIVES: to assess the knowledge, attitudes, practices and the potential role of trained Gambian traditional birth attendants (TBAs) in the prevention, recognition and management of postpartum haemorrhage (PPH). DESIGN: a qualitative, reflective approach using semi-structured interviews followed by group discussions. SETTING: poorly-resourced rural villages in The Gambia, West Africa. PARTICIPANTS: 22 trained TBAs and their supervisors from 12 villages. FINDINGS: the TBAs recognised complications such as retained placenta and excessive blood loss and were well aware of the need to refer these women to a health facility quickly. Delay in referral was often due to late call-out of the TBA or lack of transport. Although the TBAs did not know the causes of excessive blood loss, they knew that anaemia was a risk factor for dying from PPH. The TBAs were keen to improve their knowledge and to participate in further training. KEY CONCLUSIONS: although all the TBAs were illiterate, information from training programmes had usually been incorporated into their knowledge and practice. While the local infrastructure remains poor, home deliveries and delayed referrals will continue and interventions for PPH need to be effective at the site of delivery i.e. in the woman's home. These Gambian TBAs have the potential to contribute to the management of PPH in these situations.Implications for practice: these Gambian TBAs could be trained to implement other practices relevant to prevention of PPH in the primary care setting. Linking together and maximising the skills of all health workers is important to reduce PPH mortality in home births in this setting. **bij de Vaate A, Coleman R, Manneh H, Walraven G. Knowledge, attitudes and practices of trained traditional birth attendants in the Gambia in the prevention, recognition and management of postpartum haemorrhage. Midwifery. 2002 Mar;18(1):3-11.** http://www.sciencedirect.com/science?_ob=ArticleURL

	&_udi=B6WN9-45KNB6J-2&_coverDate=03%2F31%2F2002&_alid=208095265&_rdoc=1&_fmt=&_orig=search&_qd=1&_cdi=6957&_sort=d&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=fda1d33d4d63e60a76c822b8c8ebb1dc
Il n'y a pas davantage de risque nénoatal et maternel lors d'une naissance à domicile planifiée avec accompagnement d'une sage-femme.	[1049] Background The choice to give birth at home with a regulated midwife in attendance became available to expectant women in British Columbia in 1998. The purpose of this study was to evaluate the safety of home birth by comparing perinatal outcomes for planned home births attended by regulated midwives with those for planned hospital births. Methods We compared the outcomes of 862 planned home births attended by midwives with those of planned hospital births attended by either midwives (n = 571) or physicians (n = 743). Comparison subjects who were similar in their obstetric risk status were selected from hospitals in which the midwives who were conducting the home births had hospital privileges. Our study population included all home births that occurred between Jan. 1, 1998, and Dec. 31, 1999. Results Women who gave birth at home attended by a midwife had fewer procedures during labour compared with women who gave birth in hospital attended by a physician. After adjustment for maternal age, lone parent status, income quintile, use of any versus no substances and parity, women in the home birth group were less likely to have epidural analgesia (odds ratio 0.20, 95% confidence interval [CI] 0.14–0.27), be induced, have their labours augmented with oxytocin or prostaglandins, or have an episiotomy. Comparison of home births with hospital births attended by a midwife showed very similar and equally significant differences. The adjusted odds ratio for cesarean section in the home birth group compared with physician-attended hospital births was 0.3 (95% CI 0.22–0.43). Rates of perinatal mortality, 5-minute Apgar scores, meconium aspiration syndrome or need for transfer to a different hospital for specialized newborn care were very similar for the home birth group and for births in hospital attended by a physician. The adjusted odds ratio for Apgar scores lower than 7 at 5 minutes in the home birth group compared with physician-attended hospital births was 0.84 (95% CI 0.32–2.19). Interpretation There was no increased maternal or neonatal risk associated with planned home birth under the care of a regulated midwife. The rates of some adverse outcomes were too low for us to draw statistical

	comparisons, and ongoing evaluation of home birth is warranted. **Janssen, P.A., Lee, S.K., Ryan, E.M., Etches, D.J., Farquharson, D.F., Peacock, D., Klein, M.C. Outcomes of planned home births versus planned hospital births after regulation of midwifery in British Columbia. CMAJ. 2002 February 5; 166(3): 315–323.** http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=99310
Les femmes pauvres de la région des Chiapas préfèrent un accouchement traditionel qui leur donne le choix du lieu, de la position d'accouchement, de la présence de leurs proches.	[1102] This study was designed to better understand how women in a developing region choose between the multiple options available to them for birthing. We conducted focused, open-ended ethnographic interviews with 38 nonindigenous, economically marginal women in Chiapas, Mexico. We found that although medical services for birthing were readily available to them, these women most often chose traditional birth attendants (TBAs) for assistance with their births. They expressed a clear preference for TBAs in the case of a normal birth, but viewed medical services as useful for diagnosing and managing problem deliveries and for tubal ligations. They favored TBAs because they valued being able to choose birthing locations and birthing positions and to have relatives present during the birth, all features they must give up for medically attended births in this region. **Hunt LM, Glantz NM, Halperin DC. Childbirth care-seeking behavior in Chiapas. Health Care Women Int. 2002 Jan;23(1):98-118.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=11822563
L'AAD pour les femmes qui l'ont choisi ne présente pas plus de risques.	[1356] This paper reports and comments on quantitative aspects of 440 planned homebirths attended by registered midwives in Victoria during the three years studied, 1995-1998. The spontaneous labour rate was 96.4%, and 91.6% of women planning a home birth experienced a spontaneous cephalic birth. The overall transfer to hospital rate was 20%, the most common reason for transfer being delayed progress in labour. 64.2% of women experiencing a vaginal birth had no perineal trauma. Postpartum haemorrhage was noted in 5.5% of participants, and 1.1% had a retained placenta. Infants were an older gestation and heavier than those in the state in general, although the Apgar scores were similar. These data support the claim that planned home birth with a qualified midwife remains a demonstrably safe option for women who choose this model. **Parratt J, Johnston J. Planned homebirths in Victoria, 1995-1998. {Australie}.**

	Aust J Midwifery. 2002;15(2):16-25. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=12219422&query_hl=1
Plus de risques pour les bébés lors des AADs dans l'état de Washington (mais la statistique est-elle suffisante ?).	[1357] OBJECTIVE: To determine whether there was a difference between planned home births and planned hospital births in Washington State with regard to certain adverse infant outcomes (neonatal death, low Apgar score, need for ventilator support) and maternal outcomes (prolonged labor, postpartum bleeding). METHODS: We examined birth registry information from Washington State during 1989-1996 on uncomplicated singleton pregnancies of at least 34 weeks' gestation that either were delivered at home by a health professional (N = 5854) or were transferred to medical facilities after attempted delivery at home (N = 279). These intended home births were compared with births of singletons planned to be born in hospitals (N = 10,593) during the same years. RESULTS: Infants of planned home deliveries were at increased risk of neonatal death (adjusted relative risk [RR] 1.99, 95% confidence interval [CI] 1.06, 3.73), and Apgar score no higher than 3 at 5 minutes (RR 2.31, 95% CI 1.29, 4.16). These same relationships remained when the analysis was restricted to pregnancies of at least 37 weeks' gestation. Among nulliparous women only, these deliveries also were associated with an increased risk of prolonged labor (RR 1.73, 95% CI 1.28, 2.34) and postpartum bleeding (RR 2.76, 95% CI 1.74, 4.36). CONCLUSION: This study suggests that planned home births in Washington State during 1989-1996 had greater infant and maternal risks than did hospital births. **Pang JW, Heffelfinger JD, Huang GJ, Benedetti TJ, Weiss NS. Outcomes of planned home births in Washington State: 1989-1996. {USA}. Obstet Gynecol. 2002 Aug;100(2):253-9.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=12151146&query_hl=1
Humaniser la naissance pour diminuer les risques ...	[1358] Humanized birth puts the woman in the center and in control, focuses on community based primary maternity care with midwives, nurses and doctors working together in harmony as equals, and has evidence based services. Western, medicalized, high tech maternity care under obstetric control usually dehumanizes, often leads to unnecessary, costly, dangerous, invasive obstetric interventions and should never be exported to developing countries. Midwives and planned out-of-hospital births are perfectly safe for low-risk births. **Wagner M. Fish can't see water: the need to humanize birth.**

	Int J Gynaecol Obstet. 2001 Nov;75 Suppl 1:S25-37. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=11742640&query_hl=1
Le point de vue des soignants français sur les maisons de naissance: sur les 42% ayant répondu au questionnaire, 80% ne connaissaient pas les maisons de naissance.	[1367] Une enquête par questionnaire est réalisée auprès des praticiens en gynécologie et obstétrique de l'Isère au sujet du projet de Maison de naissance dans ce département. Le but est de mieux connaître l'opinion des professionnels sur l'organisation du système de santé autour de la naissance, sur leurs suggestions et critiques envers ce projet. Sur 451 personnes interrogées, on obtient 42 % de réponses, dont 72,6 % de sages-femmes et 21 % de médecins gynécologues ou obstétriciens. Cette étude est effectuée en trois temps : entretiens exploratoires auprès des praticiens, rédaction du questionnaire comprenant 37 questions puis analyse des réponses groupées autour de neuf thèmes : information des professionnels sur les Maisons de naissance, questions de « connaissance » sur ces structures, pratique de la préparation à la naissance, avis des praticiens sur certains principes pratiques des Maisons de naissance, les compétences de la sage-femme, la satisfaction des professionnels à propos de l'organisation du système de soins autour de la naissance, comment améliorer la prise en charge de la naissance en France, les praticiens sont-ils favorables à ce projet, les déterminants sociaux. Les résultats de cette enquête révèlent que les professionnels sont très mal informés (environ 20 % connaîtraient ces structures). On remarque également un taux élevé de mécontents face au système de santé actuel autour de la naissance (78 %). La majorité (de 38 à 88 %) s'est prononcée favorablement pour chaque principe inhérent à cette structure (pas de déclenchement, sortie précoce avec HAD, meilleure information sur l'analgésie péridurale, choix de la position pendant le travail et l'accouchement…), mais les avis sont très divergents au sujet du monitorage foetal discontinu pendant le travail et l'absence de possibilité d'analgésie péridurale en Maison de naissance. Quatre-vingt pour cent acceptent ce projet. Cependant, 20 % pensent qu'un ou plusieurs médecins sont disponibles en permanence dans la Maison de naissance et 47 % estime que ce projet n'a pas d'intérêt en termes de mortalité/morbidité maternelle et infantile. Ceci représente un biais concernant les réponses sur l'approbation des

	professionnels pour le projet. En conséquence, avant d'envisager l'installation de Maisons de naissance en France, une première étape d'évaluation de sites pilotes ainsi qu'une large information des professionnels en gynéco-obstétrique s'imposent. Cette information devra porter sur les compétences de la sage-femme et les missions des Maison de naissance. **Viossat P, Dumitru-Daubigny L, Beaudevin C, Pons JC. [For or against birthing centers: a survey of practitioners in the Isere area] {France}. J Gynecol Obstet Biol Reprod (Paris). 2001 Nov;30(7 Pt 1):688-96.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=11917365&query_hl=2
	[1368] De nombreux pays industrialisés ont mis en place des Maisons de naissance. Aucune structure de ce type n'existe en France. Cette revue de la littérature a pour but d'analyser les publications concernant les Maisons de naissance existantes et de permettre de juger de leur efficacité en comparaison avec un fonctionnement hospitalier conventionnel. Neuf études ont été retenues, dont une prospective. Toutes mettent en évidence une amélioration en termes de morbidité et mortalité maternelle et périnatale dans le groupe des grossesses « à bas risque ». Cependant, on ne peut conclure sur l'innocuité de l'établissement de telles structures dans le système de soins français. Les effectifs des études publiées, leurs hétérogénéités, l'existence d'un seul essai prospectif nous incitent à la prudence. L'ouverture de Maisons de naissances en France devrait être précédée de travaux d'évaluation à partir de sites pilotes. **Viossat P, Pons JC. [Birthing centers: review of the literature] [in french].** **J Gynecol Obstet Biol Reprod (Paris). 2001 Nov;30(7 Pt 1):680-7.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=11917364&query_hl=2
	[133] PURPOSE: This study explored the experiences of women who were transferred from a midwife-led to a distant consultant obstetric unit before or during labor. BACKGROUND: Little attention is given to the psychological impact of transfer, particular when it takes place prior to labor. METHOD: Narrative and progressively focused

	interviews were conducted with 18 women who faced or experienced transfer prior to or during labor. The data were analyzed using a grounded theory approach. RESULTS: The core category in the transferred group was loss. This related to loss of choice, control, continuity, and support and was associated with anger and resentment. Distress appeared most common when transfer took place late in a healthy pregnancy when the mother recognized no risk to the baby. CONCLUSIONS: More attention needs to be paid to the psychological impact of transfer from midwife-led to consultant-led care, particularly where this involves a change of location or midwife. **Walker J. Women's experiences of transfer from a midwife-led to a consultant-led maternity unit in the UK during late pregnancy and labor.** **J Midwifery Womens Health. 2000 Mar-Apr;45(2):161-8.** http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6W6R-40BH2YW-C&_coverDate=04%2F30%2F2000&_alid=120677385&_rdoc=1&_fmt=&_orig=search&_qd=1&_cdi=6605&_sort=d&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=7e9bc9da65f565d4700585b95ec4a034 Remarques : Acces libre au resume, texte payant.
	[546] OBJECTIVE: To compare the outcome of care given to women 'booking' for delivery in a midwife-led maternity unit with that for comparable women 'booking' for care in a consultant obstetric unit. DESIGN AND METHOD: Prospective cohort study with a quasi-experimental design and data extracted from case notes. SETTING: East Dorset, midwife-led maternity unit at Royal Bournemouth Hospital and consultant-led maternity unit at Poole General Hospital. SUBJECTS: Two cohorts of women who satisfied the criteria for 'booking' at the Royal Bournemouth Hospital. Of these 794 'booked' at Bournemouth from 1 November 1992 to 30 June 1993 and 705 'booked' at Poole over the same period. MAIN PROCESS AND OUTCOME MEASURES: Care given, morbidity in women and their babies, transfers during the antenatal period and in labour. FINDINGS: Of the women who initially 'booked' for Bournemouth, 62.3% actually delivered there, 27.1%

	transferred before labour and a further 9.2% transferred during labour. No differences were seen between those 'booked' for Bournemouth or Poole in the proportions of low birthweight babies, babies who were transferred to special care or babies who had congenital abnormality. Higher proportions of babies whose mothers 'booked' for delivery in Poole were resuscitated and had one minute Apgar scores below seven but there was no difference in the five minute scores. Similar proportions of women had perineal tears but fewer of the women 'booked' for delivery in Bournemouth had an episiotomy. 'Booking' for Poole was associated with higher rates of induction and augmentation of labour and greater use of anesthesia. 'Booking' for Bournemouth was associated with a shorter first stage and a longer third stage of labour. Women 'booked' for delivery in Bournemouth were no more likely to be delivered by a midwife than those 'booked' for Poole. CONCLUSIONS: There was very little difference between the groups of women who initially 'booked' for delivery at the two units. There were differences in the patterns of care received, but no major differences in the outcome for the women or their babies were detected. **Campbell R, Macfarlane A, Hempsall V, Hatchard K. Evaluation of midwife-led care provided at the Royal Bournemouth Hospital. Midwifery. 1999 Sep;15(3):183-93.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=10776243&dopt=Abstract
Moins d'interventions dans les "birth centres" que dans les hôpitaux, avec les mêmes résultats périnataux (Berlin).	[567] OBJECTIVE: Our purpose was to compare birth complications and fetal outcome in hospitals and birth centers. METHOD: We retrospectively compared all 801 deliveries between 1992 and 1994 from two free-standing birth centers against 3271 hospital deliveries in Berlin. The hospital collective was selected according to the same risk criteria of the birth centers. RESULTS: The birth center group had significantly fewer medical interventions, with a similar cesarean section rate (3.0% vs. 4.6%, P = 0.057) and occurrence of severe perineal lesions. The episiotomy rate was significantly higher (P < 0.001) in the clinics for first-time and multiple births. The perinatal mortality was not significantly different (< 0.1 per 1000). One-minute Apgar scores less than 7 were found significantly more often in the birth center group. CONCLUSION: When birth centers employ thorough risk

	selection and significant early referral rates to nearby hospitals, there is no evidence of increased maternal or perinatal risk compared to hospital deliveries. **David M, von Schwarzenfeld HK, Dimer JA, Kentenich H. Perinatal outcome in hospital and birth center obstetric care.** **Int J Gynaecol Obstet. 1999 May;65(2):149-56.** http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T7M-3X889XF-7&_coverDate=05%2F01%2F1999&_alid=153844189&_rdoc=1&_fmt=&_orig=search&_qd=1&_cdi=5062&_sort=d&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=3c5c55b115974fc9800e13c242bcd5a3
Accouchement à domicile : plus de périnées intacts. Noter aussi l'influence négative du lubrifiant et du massage périnéal.	[709] CONTEXTE: Les déchirures périnéales sont une source importante de désagréments pour beaucoup de femmes. Dans cette étude descriptive, nous examinons l'état du périnée dans une population de femmes ayant accouché à domicile, et donnons une description préliminaire des facteurs associés aux déchirures périnéales et à l'épisiotomie. METHODES: Etude de cohorte prospective de 1404 accouchements à domicile planifiés. Les analyses sont concentrées sur 1068 femmes ayant accouché à domicile avec une sage-femme, et 28 cabinets de sages-femmes. Les traumatismes périnéaux incluent l'épisiotomie et les déchirures. Les écorchures mineures et déchirures superficielles qui n'ont pas nécessité de suture sont incluses dans le groupe des périnées intacts. Les liens entre les traumatismes périnéaux et les variables de l'étude ont été examinés globalement, et séparément pour les femmes multipares et primipares. RESULTATS: Dans cet échantillon, 69.6% des femmes avaient un périné intact, 15 (1.4%) ont eu une épisiotomie, 28.9% avaient une déchirure du premier ou deuxième degré, et 7 femmes (0.7%) des déchirures du troisième ou quatrième degré. Des analyses basées sur des régressions logistiques montrent que les périnées intacts sont associés à la multiparité, à un niveau socio-économique faible, et à une parité élevée, alors que les traumatismes périnéaux sont associés à un âge avancé (> ou = à 40 ans), à une épisiotomie précédente, à un gain de poids de plus de 9 kilos, à un second stade du travail prolongé, et à l'utilisation d'huiles ou de lubrifiants. Parmi les primipares, les périnés intacts sont associés à un niveau socio-économique faible, à une position d'accouchement à genoux ou à quatre pattes, et à un maintien manuel du périnée, alors que les traumatismes du périné sont associés aux massages de celui-ci pendant l'accouchement.

	CONCLUSIONS: Ces résultats suggèrent qu'il est possible que les sages-femmes parviennent à obtenir un taux élevé de périnées intacts dans un lieu choisi et avec une population sélectionnée. **Aikins Murphy P, Feinland JB. Perineal outcomes in a home birth setting.** **Birth. 1998 Dec;25(4):226-34.** http://www.blackwell-synergy.com/openurl?genre=article&sid=nlm:pubmed&issn=0730-7659&date=1998&volume=25&issue=4&spage=226
AAD sur pour des grossesses à bas risque bien sélectionnées.(mais toujours statistiques justes).	[1359] OBJECTIVE: To describe the outcomes of intended home birth in the practices of certified nurse-midwives. METHODS: Twenty-nine US nurse-midwifery practices were recruited for the study in 1994. Women presenting for intended home birth in these practices were enrolled in the study from late 1994 to late 1995. Outcomes for all enrolled women were ascertained. Validity and reliability of submitted data were established. RESULTS: Of 1404 enrolled women intending home births, 6% miscarried, terminated the pregnancy or changed plans. Another 7.4% became ineligible for home birth prior to the onset of labor at term due to the development of perinatal problems and were referred for planned hospital birth. Of those women beginning labor with the intention of delivering at home, 102 (8.3%) were transferred to the hospital during labor. Ten mothers (0.8%) were transferred to the hospital after delivery, and 14 infants (1.1%) were transferred after birth. Overall intrapartal fetal and neonatal mortality for women beginning labor with the intention of delivering at home was 2.5 per 1000. For women actually delivering at home, intrapartal fetal and neonatal mortality was 1.8 per 1000. CONCLUSION: Home birth can be accomplished with good outcomes under the care of qualified practitioners and within a system that facilitates transfer to hospital care when necessary. Intrapartal mortality during intended home birth is concentrated in postdates pregnancies with evidence of meconium passage. **Murphy PA, Fullerton J. Outcomes of intended home births in nurse-midwifery practice: a prospective descriptive study. {USA}.** **Obstet Gynecol. 1998 Sep;92(3):461-70.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=9721790&query_hl=1
	[248] La fin des années 70 a vu émerger une réalité qui a bouleversé la culture de la naissance québécoise : l'accouchement à la maison et l'arrivée de nouvelles sages-femmes. Bien qu'en 1997 nous nous dirigeons vers la légalisation des

	sages-femmes et qu'il y a des Maisons de naissance au Québec, il continue à y avoir des accouchements à la maison et cette réalité demeure un sujet délicat à tous les niveaux de parole et de pouvoir. A partir de la construction de deux récits, celui des femmes et celui des sages-femmes, j'ai fait une analyse sémiologique des représentations autour de quatre grands thèmes : la maison, l'accouchement, la douleur et le risque, éclairant ainsi la cosmogonie de l'accouchement à la maison, témoignant d'un autre rapport au monde. L'analyse anthropologique des voix du dedans permet de saisir la valeur sémiotique de « la maison ». Elle a des fonctions de protection, de cohésion, d'ancrage et d'intégration, et l'accouchement peut s'y insérer dans la logique de ses représentations à l'intérieur d'une quête de cohérence et de vérité. Nous pouvons ensuite comprendre que la douleur s'insère dans le tout de l'accouchement comme événement normal de la vie. Pour les femmes, elle est un signe d'humanité, d'effort et de l'intensité de l'accouchement tandis que les sages-femmes voient en elle un signe de séparation, de transformation, de passage et lui reconnaissent une valeur initiatique. Enfin, le risque n'est pas la seule grille d'évaluation de la mise au monde. Le sentiment de sécurité et la confiance des femmes sont à l'intérieur d'elles et la relation avec les sages-femmes s'inscrit dans un ordre féminin où le pouvoir est partagé. L'analyse du noyau de subjectivité de l'accouchement à la maison permet sans doute d'éclairer les représentations de celles qui le vivent mais le contraste avec la trame de fond sociosymbolique québécoise révèle alors cette réalité comme discours. Ainsi, l'accouchement à la maison est l'affirmation que l'accouchement ne se définit pas comme un événement médical. Il exprime que l'humanisation n'est pas seulement la capacité de choisir. Elle est aussi le pouvoir de nommer, de définir et de signifier ce qu'est accoucher, souffrir et vivre le risque. L'accouchement à la maison révèle qu'avec les sages-femmes, il fait parti d'un ordre féminin, qu'il s'inscrit dans la vie comme un système et comme un tout, et il affirme que la vie comporte des risques.

	Il témoigne enfin de la richesse des représentations autour de la naissance, il confirme que la science n'est qu'une strate du savoir et que les femmes pensent autrement. **Lemay, C. L'accouchement à domicile au Québec : les voix du dedans. Mémoire de maîtrise en anthropologie, Université de Montréal, Canada.** http://www.fraternet.org/naissance/docs/clemay/memoire.html
Les mesures de satisfaction de vécu de l'accouchement donnent des résultats incohérents car elles ne sont pas basées sur les bons critères.	[1104] OBJECTIVE: 1. To explore whether there are differences in women's satisfaction with care in a midwife-managed delivery unit compared with that in a consultant-led labour ward. 2. To compare factors relating to continuity, choice and control between the two randomised groups. DESIGN: A pragmatic randomised controlled trial. SETTING: Aberdeen Maternity Hospital, Grampian. SAMPLE: 2844 women, identified at booking as low risk, were randomised in a 2:1 ratio between the midwives' unit and the labour ward. MAIN OUTCOME MEASURES: Satisfaction, continuity of carer, choice, and control. RESULTS: Satisfaction with the overall experience did not differ between the groups. Satisfaction with how labour and delivery was managed by staff was slightly higher in the midwives' unit group, but this did not reach the 0.1% level of significance. Women allocated to the midwives' unit group saw significantly fewer medical staff and were less likely to report numerous individuals entering the room. They were more likely to report having had a choice regarding mobility and alternative positions for delivery and were significantly more likely to have made their own decisions regarding pain relief. CONCLUSIONS: The issues surrounding the measurement of satisfaction with childbirth need further investigation. Until this area is clarified it would be unwise to use an overall measure of satisfaction as an indicator of the quality of maternity service provision. In particular, the current measures are not sensitive enough to examine the specific factors which affect women's satisfaction. Further research is required to assess which factors are important to women if they are to have a positive experience of childbirth and how these priorities change over time. **Hundley VA, Milne JM, Glazener CM, Mollison J. Satisfaction and the three C's: continuity, choice**

	and control. Women's views from a randomised controlled trial of midwife-led care. Br J Obstet Gynaecol. 1997 Nov;104(11):1273-80. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=9386028
	[1129] BACKGROUND: The safety of birth center care for low-risk women is an important issue, but it has not yet been studied in randomized controlled trials. Our purpose was to evaluate the effect of birth center care on women's health during pregnancy, birth, and 2 months postpartum by comparing the outcomes with those of women experiencing standard maternity care in the greater Stockholm area. METHODS: Of 1860 women, 928 were randomly allocated to birth center care and 932 to standard antenatal, intrapartum, and postpartum care. Information about medical procedures and health outcomes was collected from clinical records, and a questionnaire was mailed to women 2 months after the birth. Analysis was by "intention to treat;" that is, all antenatal, intrapartum, and postpartum transfers were included in the birth center group. RESULTS: During pregnancy, birth center women made fewer visits to midwives and doctors, experienced fewer tests, and reported fewer health problems. No statistical difference occurred in hospital admissions (4.8%) compared with the control group (4.7%). During labor, birth center women used more alternative birth positions, had longer labors, and did not differ in perineal lacerations. In both groups 1.7 percent of women developed complications, requiring more than 7 days of hospital care after the birth. During the first 2 postpartum months, about 20 percent of women in both groups saw a doctor for similar types of health problems, and no statistical difference occurred in hospital readmissions, 1.4 and 0.8 percent in the birth center and control groups, respectively. CONCLUSION: The results suggest that birth center care is effective in identifying significant maternal complications and as safe for women as standard maternity care. **Waldenstrom U, Nilsson CA. A randomized controlled study of birth center care versus standard maternity care: effects on women's health. Birth. 1997 Mar;24(1):17-26.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=9271963
L'AAD est sur pour des femmes à bas risques	[1360] AIMS: To determine for the period 1973-93, national and regional (1991 and 1992 only)

en Nouvelle Zélande.	incidence of home birth in New Zealand, with home birth defined as home being the intended place of birth at the onset of labour, to calculate perinatal and maternal mortality rates for home birth, and to categorise the cause of perinatal death. METHODS: Data sheets for 9776 planned home births were analysed. These had been collected by the Home Birth Associations of New Zealand/Aotearoa. National perinatal data and data from National Women's Hospital, Auckland were used for comparison. Trend analysis was performed by Poisson regression allowing for overdispersion. RESULTS: Planned home birth made up 2% of the total births in 1993, up from 0.04% in 1973. The home birth perinatal mortality rate for this period was 2.97 per 1000 total births, with no change over time. This was not significantly different from the rate for a selected low risk group at National Women's Hospital. Lethal anomalies caused 31% of the perinatal deaths. There was one maternal death (maternal mortality rate: 1.02 per 10,000 total births). There were significant differences in the rate of home birth in separate area health board regions for 1991 and 1992. CONCLUSION: Home birth was a safe and increasingly popular: though minor, option for New Zealand women from 1973-93. **Gulbransen G, Hilton J, McKay L, Cox A. Home birth in New Zealand 1973-93: incidence and mortality. {Nouvelle Zélande}.** **N Z Med J. 1997 Mar 28;110(1040):87-9.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=9137308&query_hl=1
L'AAD est sur pour les femmes à bas risques, méta-analyse sur 24000 naissances.	[1361] BACKGROUND: The safety of planned home birth is controversial. This study examined the safety of planned home birth backed up by a modern hospital system compared with planned hospital birth in the Western world. METHODS: A meta-analysis of six controlled observational studies was conducted, and the perinatal outcomes of 24,092 selected and primarily low-risk pregnant women were analyzed to measure mortality and morbidity, including Apgar scores, maternal lacerations, and intervention rates. Confounding was controlled through restriction, matching, or in the statistical analysis. RESULTS: Perinatal mortality was not significantly different in the two groups (OR = 0.87, 95% Ci 0.54-1.41). The principal difference in the outcome was a lower frequency of low Apgar scores (OR = 0.55; 0.41-0.74) and severe lacerations (OR = 0.67; 0.54-0.83) in the home birth group. Fewer medical interventions occurred in the home birth group: induction (statistically significant ORs in the

	range 0.06-0.39), augmentation (0.26-0.69), episiotomy (0.02-0.39), operative vaginal birth (0.03-0.42), and cesarean section (0.05-0.31). No maternal deaths occurred in the studies. Some differences may be partly due to bias. The findings regarding morbidity are supported by randomized clinical trials of elements of birth care relevant for home birth, however, and the finding relating to mortality is supported by large register studies comparing hospital settings of different levels of care. CONCLUSION: Home birth is an acceptable alternative to hospital confinement for selected pregnant women, and leads to reduced medical interventions. **Olsen O. Meta-analysis of the safety of home birth.** **Birth. 1997 Mar;24(1):4-13; discussion 14-6.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=9271961&query_hl=1
	[2000] Objectif: Etudier la relation entre le lieu d'accouchement décidé à l'avance (domicile ou hôpital) et les résultats périnataux pour des grossesses à bas risque, avec vérification de la parité des données et de l'environnement social, médical et obstétrical. Méthode: Analyse des données statistiques des sages-femmes et de leur clientèle. Echantillon: 54 cabinets de sages-femmes de la province de Gelderland aux Pays-Bas. Population: 97 sages-femmes et 1836 femmes avec grossesse à faible risque qui avaient décidé d'accoucher à domicile ou à l'hôpital. Principaux résultats analysés: Indice des résultats périnataux sur la base d'un "résultat maximal avec intervention minimale" comprenant 22 critères relatifs à l'accouchement, 9 à l'état de santé du nouveau-né et 5 à l'état de santé de la mère après la naissance. Résultats: Il n'y a pas de relation entre le lieu d'accouchement projeté et le résultat périnatal pour les femmes primipares si l'on tient compte de l'environnement plus ou moins favorable. En ce qui concerne les multipares, les résultats périnataux sont nettement meilleurs pour des naissances planifiées à domicile que pour des naissances planifiées à l'hôpital, que l'on tienne compte ou non des variables d'environnement. Conclusions: Les résultats des accouchements

	planifiés à domicile sont au moins aussi bons que ceux des accouchements planifiés à l'hôpital pour les femmes ayant des grossesses à faible risque assistées par des sages-femmes aux Pays-Bas. **T A Wiegers, M J N C Keirse, J van der Zee, & G A H Bergh. Outcome of planned home and planned hospital births in low risk pregnancies: prospective study in midwifery practices in the Netherlands. British Medical Journal, 1996; 313: 1309-1313.** http://naissance.ws/docs/wiegers/ Remarques : L'URL pointe vers une version française simplifiée qui contient l'adresse du texte intégral en anglais. Full text in English: http://bmj.bmjjournals.com/cgi/content/full/313/7068/1309
	[7] Award winning medical writer and birth activist Henci Goer gives clear, concise information based on the latest medical studies. Goer will help you compare and contrast your various options and show you how to avoid unnecessary procedures, drugs, restrictions, and tests. **Goer, Henci. The Thinking Woman's Guide to a Better Birth. Practical Information for a Safe, Satisfying Childbirth. New York: Berkley.** http://www.hencigoer.com/betterbirth/ Remarques : C'est une nouvelle édition de son ouvrage "Obstetric Myths Versus Research Realities", mais nous conseillons d'utilser les deux… Pour commander l'ouvrage: http://www.amazon.fr/exec/obidos/ASIN/0399525173/
	[30] "Le lieu de la naissance." -- Ce chapitre compare les avantages et inconvénients (aux USA) des accouchements à l'hôpital, dans les centres de naissance (Freestanding Birth Centers), et à domicile. Il compare aussi les services des obstétriciens, des sages-femmes autodidactes ("direct-entry") et des sages-femmes-infirmières ("nurse-midwives"). **Goer, Henci. The Place of Birth: Location. In "The Thinking Woman's Guide to a Better Birth. Practical Information for a Safe, Satisfying Childbirth." New York: Berkley, p.201-218** http://www.hencigoer.com/betterbirth/

	Remarques : Pour commander l'ouvrage: http://www.amazon.fr/exec/obidos/ASIN/0399525173/
Aucune donnée scientifique ne confirme la thèse selon laquelle le choix le plus sûr pour toute femme serait d'accoucher à l'hôpital	[41] Mythe: L'accouchement à domicile est si dangereux qu'il devrait être considéré comme de la maltraitance infantile. Réalité: Aucune donnée scientifique ne confirme la thèse selon laquelle le choix le plus sûr pour toute femme serait d'accoucher à l'hôpital […] Par contre, des études montrent […] que la morbidité est plus élevée parmi les mères et les bébés nés et suivis dans une institution en général, [.] et tout particulièrement dans les services obstétricaux. **Goer, Henci. Home Birth [L'accouchement à domicile]. In Obstetric Myths Versus Research Realities: A Guide to the Medical Literature. Westport: Bergin & Garvey, p.275-293** http://naissance.ws/docs/homebirth-fr.htm Remarques : Pour commander l'ouvrage: http://www.amazon.com/exec/obidos/tg/detail/-/0897894278/
	[1072] During the decade 1960 to 1969, perinatal mortality rates in Newcastle upon Tyne fell in parallel with national trends, in association with a marked reduction of domiciliary midwifery. Analysis of the records of women booked for confinement at home or in specialist hospitals showed that the reduction of mortality occurred with unexpected uniformity in both categories, in low risk as well as high risk patients, and in all causes of mortality except congenital malformations. It could not be attributed to improvements in maternal characteristics nor to increased size of babies at birth. The most probably explanation seems to be a combination of many improvements in the quality of care, with increased awareness of risks, better selection of high-risk groups, and improved supervision and management throughout. There is no indication that single factor in obstetric management, such as more intervention during labour, had a dominant effect. **Barron SL, Thomson AM, Philips PR. Home and hospital confinement in Newcastle upon Tyne 1960-69. Br J Obstet Gynaecol 1977;84:401-11.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=889735&dopt=Abstract Remarques : This study in the United States matched 1046 women who, immediately before the onset of labour, intended to give birth at home,

	with a similar group of women intending to give birth in hospital. The women were matched for age, education, socioeconomic status and obstetric risk factors. Although the incidence of episiotomy was nine times higher among hospital deliveries, there was a statistically significant excess in the number of second, third, and fourth degree lacerations in women delivered in hospital compared with those who gave birth at home. A significantly greater proportion of babies born in hospital had birth injuries, neonatal infections, respiratory distress lasting 12 hours or more and non-congenital neonatal complications. There were, however, no statistically significant differences in mortality or neurological impairment.