CUISR:

Community – University Institute for Social Research

Refugee Women and Their Postpartum Experiences

by Claire Roberts

Building Healthy Sustainable Communities

Community-University Institute for Social Research

CUISR is a partnership between a set of community-based organizations (including Saskatoon District Health, the City of Saskatoon, Quint Development Corporation, the Saskatoon Regional Intersectoral Committee on Human Services) and a large number of faculty and graduate students from the University of Saskatchewan. CUISR's mission is "to serve as a focal point for community-based research and to integrate the various social research needs and experiential knowledge of the community-based organizations with the technical expertise available at the University. It promotes, undertakes, and critically evaluates applied social research for community-based organizations, and serves as a data clearinghouse for applied and community-based social research. The overall goal of CUISR is to build the capacity of researchers, community-based organizations and citizenry to enhance community quality of life."

This mission is reflected in the following objectives: (1) to build capacity within CBOs to conduct their own applied social research and write grant proposals; (2) to serve as a conduit for the transfer of experientially-based knowledge from the community to the University classroom, and transfer technical expertise from the University to the community and CBOs; (3) to provide CBOs with assistance in the areas of survey sample design, estimation and data analysis, or, where necessary, to undertake survey research that is timely, accurate and reliable; (4) to serve as a central clearinghouse, or data warehouse, for community-based and applied social research findings; and (5) to allow members of the University and CBOs to access a broad range of data over a long time period.

As a starting point, CUISR has established three focused research modules in the areas of Community Health Determinants and Health Policy, Community Economic Development, and Quality of Life Indicators. The three-pronged research thrust underlying the proposed Institute is, in operational terms, highly integrated. The central questions in the three modules—community quality of life, health, and economy—are so interdependent that many of the projects and partners already span and work in more than one module. All of this research is focused on creating and maintaining healthy, sustainable communities.

Research is the driving force that cements the partnership between universities, CBOs, and government in acquiring, transferring, and applying knowledge in the form of policy and programs. Researchers within each of the modules examine these dimensions from their particular perspective, and the results are integrated at the level of the Institute, thus providing a rich, multi-faceted analysis of the common social and economic issues. The integrated results are then communicated to the Community and the University in a number of ways to ensure that research makes a difference in the development of services, implementation of policy, and lives of the people of Saskatoon and Saskatchewan.

CUISR gratefully acknowledges support from the Social Sciences and Humanities Research Council of Canada through their Community University Research Alliance program. CUISR also acknowledges the support of other funding partners, particularly the University of Saskatchewan, the City of Saskatoon, Saskatoon Health Region, Quint Development Corporation, and the Star Phoenix, as well as other community partners. The views expressed in this report, however, are solely those of the authors.

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CUISR acknowledges the following for their contributions to this publication:

Nazeem Muhajarine, Academic Co-Director, CUISR; and Academic Co-Leader;

Johnmark Opondo, Community Co-Leader,

Community Health Determinants and Health Policy Module, CUISR

Kate Waygood, Community Co-Director, CUISR

D & S Editing / Neil Soiseth, Editing, Interior Layout, and Design

Printed in Canada by Printing Services, University of Saskatchewan

Abstract

Available research has suggested that refugee women are at a higher risk for postpartum adjustment problems than those in the host country's population because of immigration experiences. The experiences of refugee women interviewed for this study indicate that the birth method played a more central role contributing to a difficult postpartum adjustment period than immigration experiences. Seven of the fifteen women interviewed had given birth by cesarean section. The birth and recovery period for women who underwent a cesarean section was much more traumatic than those who had given birth vaginally. The main issues facing women who gave birth vaginally were related to the larger context of their situation, such as a lack of support and stress. Women who had emergency cesarean sections focused on the details of their surgery and post-surgery, indicating the importance of the experience. For all women, the birth of their child often represented hope for the family's future. This study's findings explore some of the cultural and social reasons for the difficulties experienced by refugee women who have emergency cesarean sections.

Introduction

Studies that concluded that refugee women suffer from higher rates of postpartum adjustment difficulties and depression used the Edinburgh Postnatal Depression Scale, a ten-point questionnaire, to measure depression (Glasser, Barell, Boyko, Ziv, Lusky, and Shoham, 2000; Zelkowitz and Milet, 1995; Barclay and Kent, 1998). Use of this scale with refugee women has been criticized because the questions contain assumptions about what constitutes normal experiences (Barnett, Matthey, and Boyce 1999). The scale does not encompass the range of trauma typical of the refugee experience. Studies that have used this scale indicate that refugee women suffer from higher levels of postpartum depression, but do not provide information about why they find it difficult. The research questions and method were therefore chosen based on this scale's limitation and through close collaboration with the Saskatoon Open Door Society (SODS), a non-profit organization that provides settlement services to over 1,500 immigrants and refugees each year.

In depth interviewing was deemed the best method to discover particular postpartum difficulties, especially because the women interviewed had a range of English competency. Women were asked about their birth story, their specific cultural practices, where they found support, and their interaction with health care professionals.

This study's most significant findings revealed that refugee women who undergo an emergency cesarean section may be at a higher risk for postpartum difficulties and may need increased support in the postpartum period. Additionally, for all women having a baby contributed to feeling settled in Canada.

METHODOLOGY

The researcher attended parent classes at SODS and discussed the study with the women. Most of the participants were recruited via this meeting. (The facilitator of the parent class left the room to ensure the women's confidentiality.) As a past SODS employee (1996-1999), the researcher was able to recruit two participants through chance meetings in Saskatoon.

When in-depth interviews are used, the researcher often becomes an instrument for the study. After an unsatisfactory and awkward first interview, the researcher changed styles and became an instrument or interview tool. Rather than read consecutively through a prepared list of questions, the researcher started the interview by asking the women to talk about their babies' birth. When appropriate, the researcher interjected with prepared questions. This was a natural and successful interview style that helped to de-formalize the process. This method enabled the researcher to adapt her style and manner of questioning to the participant's comfort level.

The interviews were held in the women's homes and lasted approximately one hour, with time before and after for tea and informal discussion. Interviews were recorded on a small tape recorder, and women were visited a second time to let them review and make changes to the transcripts. Many of the women could not read in English so transcripts were read to them. Children were present for both the interviews and follow up visits.

Grounded theory was used for analysis of the interviews, and structured coding eased analysis of a diverse set of themes. The computer software program ATLAS.ti aided coding.

After fifteen interviews were completed, an informal focus group was held with SODS employees who worked with the women interviewed. The findings were presented and a discussion ensued. Of the six women who participated, five had immigrated to Canada and could relate personally to the experiences of the women in the study.

The University of Saskatchewan Advisory Committee on Ethics in Behavioural Science Research approved this research study. Names have been changed and italics indicate the researcher's questions.

Participants

Participant eligibility included being an immigrant refugee woman who had given birth in the last five years and had fair to good English competency. Nine women came from southern or northwest Africa, four from Southeast Asia, and two from the Middle East. The women had been in Canada as short as one year and as long as seven years. The women had between one and seven children. Some had left children in their country of origin or lost them in conflict. The women ranged from eighteen to thirty-six years of age and had a variety of educational backgrounds, from no schooling to a university education. All but one were married, and the lone exception lived with her extended family. The women referred to each other throughout the interview process and sometimes cited each other as supports.

Findings and Discussion

The biggest contributing factor to postpartum difficulties in the interviewed women was the experience of an emergency cesarean section. This trauma was related to cultural perceptions of the surgery and fears of the unknown, the death of her baby, and herself.

Of the seven women, two were going to give birth for the first time. Women who underwent cesarean sections did not know what was going on, and their inability to effectively communicate their confusion had adverse consequences. None of the women had had a previous cesarean section, and only one understood the specific reason for her cesarean section. They were told that if they did not have the procedure, they or their baby would die:

> **June**: [I was told,] "You have big problem, you cannot give this baby by normal. You have to have baby by cesarean in one hour. … [If] you pass this hour you will die."

> **Lucy**: The nurses came and looked at the baby and they were not happy. *Not happy?* They not happy inside. Nurses go tell the doctor and the doctor say I have to go and take the surgery. *You had a c-section?* Yeah, yeah, because the baby is not healthy.

> **Bernadette**: They put me on the table and … cut here and here. After that I felt so much pain [laugh]. After the second day, [laugh] oh, my goodness! *Do you know why you had a cesarean section?* No, I don't know.

Women who were told that they had to have an emergency cesarean section described a period of negotiation with health care workers. Despite language barriers, women could say "no." The following participant described her situation in which she was very explicit with the health care workers:

> **Anna**: And she told me, "Why no surgery?" I'm saying no. No surgery, is no good. And she told me the baby's dying. I saying, "It's okay, the baby's dying. It's okay. I am good. The baby's dying, that's okay." … The baby's dying, and you sign, and go to the other room, and surgery yeah. And I say no.

To this woman, however, the cesarean section represented the threat of death. Anna knew that she could have other children, but if she died there would be no one to take care of her husband and children. Another woman, confident of her ability to give birth, as she had done so many times in her country of origin, related her determination to give birth vaginally:

> **Gisella:** I thought I was going to come and have an operation. I decided that whatever it took that baby was coming out.

The adamant refusal or negotiation of women to not have a cesarean section may cause great confusion in the already stressful and complicated birth process. This fear and refusal has been found among refugee women in other studies. A study on the obstetric care of a South East Asian population found that three out of twelve women refused their cesarean sections, even after having it explained by physicians and translators (Schauberger, Hammes, and Steingraeber, 1990). The cesarean sections were court ordered after it was ascertained that the women could not understand due to language and cultural barriers.

Cultural context is important for understanding fears of cesarean sections. In the following case, this woman's fear was associated with the fact that in her country there was a thriving black market for organs. In some hospitals, organs were removed during surgery, unbeknownst to the patient:

> **June:** I had a very good doctor, but the problem was that I was afraid that they wanted to do a cesarean because they wanted to take my organs to make money.

This woman recognized her vulnerability. When this fear was discussed in a focus group with SODS staff, it was confirmed that this was a normal reaction based on what occurs in some countries:

> **FG [Focus Group]**: I have heard this before from immigrant and refugee women. They think they take your blood, they think they take their organs.

In countries with high maternal mortality rates, introducing surgery increases the potential for death. In a study on cesarean section deliveries at the Tikur Anbessa Teaching Hospital in Ethiopia, the main cause of maternal death was failure to control bleeding during cesarean section operations (Tadesse et al, 1996). Erin was candid about the fear that she felt when she was told that she would have to have a cesarean section:

> **Erin:** When they kept me I was shaking in my body, I was so scared. *In your country are cesarean sections quite common?* Yeah, but they say it is bad, very bad. I am thinking it is all bad.

Two women described being too distraught to sign the papers giving the hospital permission to perform the surgery, so their husbands had to sign for permission:

> **Anna**: I am no surgery. I'm crying, crying, and my husband told me, "Yeah, it's okay, go to them and sign. And the surgery is okay." No, I'm not good. I'm crying, crying. And my husband, he sign.

> **Erin***: Was your husband with you?* Yeah, they said you have to sign. I couldn't sign. I was just scared and was crying.

The full range of trauma, psychosocial outcomes, and implications for the mother-child relationship is not explored in this study. However, the women interviewed were asked to discuss their personal reactions to their cesarean section. The reactions of refugee women in this study included immediate physical trauma, anger, and anxiety over subsequent births.

Women who have cesarean sections have physical wounds that require bed rest to heal. Women may experience increased pain as a result of the healing process. Ac-

commodating bed rest may be difficult for refugee families, especially when there are other children at home. Besides trying to deal with an increased need for help at home, the women had to deal with the pain from their cesarean sections. June's pain was so debilitating that she could not walk:

> **June**: My husband, he was carrying me for many days. I could not walk. [Loud moan]. And I was just crying day and night. I was in so much pain.

Like June, Lucy could not walk as a result of her pain. Rocell also remembered being in a great deal of pain:

> **Lucy**: I can't walk. That time, my surgery, pain a lot.

> **Rocell**: That time, there was so much pain.

Bernadette compared the pain of her cesarean section to the uncomplicated births of her five other children. When Bernadette recounted her intense pain, she used gestures and facial expressions to relate the seriousness of her pain:

> **Bernadette:** They put me on the table and [laugh] they cut me here, and after that I felt so much pain. After the second day, oh my goodness.

The experience of pain was common to all the women interviewed. The issue for women who gave birth vaginally, however, was whether they wanted to "suffer" through it or receive an epidural. Women who had cesarean sections did not have a choice, and had varying degrees of post-operative pain. In all cases it also meant a longer hospital stay. In some cases it meant an inability to walk. Longer hospital stays also had implications for families who had no one to watch their children at home.

Women who had cesarean sections felt anxiety over the potential of subsequent births. Because having a previous cesarean section is a predictor of subsequent cesarean sections, anxiety over repeating the experience is well founded (Nair, 1991).

> **June**: And I think now about having baby. [Laugh] I feel a little, little [screams, makes a face and puts face in hands]. *Nervous*? Yeah, that is it.

Anna has three children and has adamantly told her husband that she is unwilling to have another child in Canada. Towards the end of the interview, after her husband explained that in his country one's wealth was measured by the number of children one had, Anna stated that one solution was that she would simply not go to the hospital if she had another baby. In a study of the obstetrical profiles of Southeast Asian women, Schauberger et al (1990) found that they did not go to the hospital until their labour was quite advanced. Anna felt that she could give birth naturally, and that her cesarean section was a mistake. The solution to fill her role and have many children, as she saw it, was to avoid going to the hospital until she was just about to deliver her baby.

Besides the physical pain and anxiety over subsequent births, some women felt angry about their experience. When asked, June said that she felt great joy over the birth of her baby, but that she also felt angry because she still did not understand why she had had a cesarean section:

> **June**: I was happy because I have my baby and she is alive, she is okay. I was happy, but in another way I was mad. Why they make operation?

Anna and her husband were also angry over her experience to the point that Anna initially rejected her new baby:

> **Anna's husband**: I feel a little bit [angry], but she feels angry. She was saying that she was sad for a long time. And then when the baby born, and when I brought the baby to her, she cried and said, "I don't want this baby."

Anna's response to her baby is not solely related to cultural perceptions of cesarean sections. Women who come from cultures in which a cesarean section is routine also have difficulty after their babies' birth. In a London study on an emergency cesarean section's effects on the mother-child relationship, mothers who delivered by cesarean section were found to have more doubts about their capacity to care for their babies and were more depressed (Trowell, 1982). Another study found an increased incidence of postpartum depression among women who had cesarean sections (Gottlieb, 1986).

In the discussion of trauma, focus group participants felt that client characteristics, such as poor language skills, compounded a response of trauma:

> **FG**: I am sure the trauma is compounded because the women do not understand what is being said. And because of the language [problems], they [think that the doctors] are saying, "Either you die or your baby dies."

Focus group participants shared their own cultural superstitions and beliefs about cesarean sections, and were not surprised at the women's adverse reactions:

> **FG**: Some people, they have superstitions about cesarean sections. They want the baby to come out the natural way. If they don't come out the natural way, then there is something wrong with your baby or it is something you did bad.

A root cause of the adverse reactions of the women, according to the focus group participants, was the difference in worldviews between European and other countries. Women from European countries were more comfortable with technological intervention than those who came from countries where such intervention was less common:

> **FG**: Well, in Europe it is the same as … here. European babies are the same as Western babies. There is no difference. But in Asia and in Africa and the Middle East, they are all about the nature, the nature is more important.

Another focus group participant related:

> **FG**: We believe that a cesarean section goes against nature. If the baby dies, we should accept that.

Focus group participants were sympathetic to health care providers who did not understand why refugee women were having such difficulty:

> **FG**: The health care providers must have been saying, "What the hell?" Maybe in their countries they had a really hard labour, but in their countries they don't do cesarean sections because it is not common.

At the same time, it was even more necessary, in the case of refugee women, for the health care provider to explain what was happening:

> **FG**: So they need to give the explanation, they need to give a good explanation as to why they are getting one—because the baby's positions is wrong. You cannot say, "You will have one or you will die."

SODS staff were sympathetic to the reasons why health care providers stated the worst-case scenario to the refugee women without explaining its causes. They were concerned that the trauma of the cesarean section could jeopardize women's future relationship with the health care system. Information provided in the focus group may inform the staff's individual responses to their clients who have cesarean sections.

Many postpartum depression studies have found that refugee women experience greater prevalence of postpartum depression (Glasser et al, 2000; Dankner, Goldberg, Fisch, and Crum, 2000; Ghubash and Abou-Saleh, 1997). Postpartum depression predictors include: lack of social support; marital disharmony; depressive symptoms during pregnancy; history of emotional problems; and prolonged infant health problems (Nair, 1991). A meta-analysis of postpartum depression studies found that experiencing a stressful life event was also a predictor of postpartum depression (O'Hara, 1996). The women interviewed who had given birth vaginally and by cesarean section each experienced predictors of postpartum depression. Although the women felt sad and suffered a lack of support, they were able to normalize their reactions and see it as a consequence of the circumstances in which they found themselves. The women needed more help because they were lonely and sad, but despite all the predictors that would indicate a risk for postpartum depression, most concentrated on coping and making a better life for themselves, their families, and their new babies. The birth of Amelia's child also brought an improvement in the level of happiness that her family felt. The problems that they had been experiencing did not seem as daunting or difficult once the baby was born:

> **Amelia**: There are so many things that can happen. Maybe the individual will not survive, but I was there. That really comforted me. I was really happy. You know, even if I have all these problems living in a new country, I realized that my baby was alive and I was also alive, so I was coming to [i.e. regaining consciousness or recovering from the experience].

The general consensus was that the birth of a new baby brought a new focus for refugee families that minimized all other struggles, including homesickness:

> **FG:** What I have heard is a lot of people feel more grounded, they feel more a part of Canada. There is a concrete connection because their baby is born here. … People don't feel so homesick after they have a baby because they have a focus and it is not really about Canada or where they came from, but now they have a central focus and it is their baby.

Focus on the baby can help women suffering from trauma over their cesarean sections. Lucy had a very difficult birth that resulted in an emergency cesarean section. At the end of her story, Lucy stated that she was happy that she finally had a baby girl (she had a family full of boys) and that she was healthy and alive:

> **Lucy**: I was happy because I have my baby and she is alive. She is okay. I was happy.

Happiness is an expected response from new mothers. Often, it is the unhappiness or stress related to having a baby that is unexpected. Women were candid about both the hardships and triumphs that they experienced.

Being able to survive and come through the experience of flight is a major accomplishment. Having children, caring for them, and coping in a new country can result in increased feelings of independence. Theresa spoke about independence:

> **Theresa**: Even someone could help you with the child at night because the child is crying. … Maybe … we used to get help, but here you can't really do anything. It is a good experience, though, because you are independent.

The experience of becoming independent was also positive for Amelia. Members of extended families rely heavily on one another in the women's countries of origin. For Amelia, the experience of immigrating and "doing something on your own" provides a feeling of growth:

> **Amelia:** Yeah, it is a good experience because you have to learn to live your life by yourself. It is important, too, because sometimes you need to do something on your own.

The women spoke about the pain of separation from family and a support structure, yet the simultaneous reward of increased independence. Amelia and Theresa both regarded the emergence from dependence on a larger family structure to existing independently of that structure as a good and rewarding experience, even though they suffered from homesickness.

Both the refugee women and SODS staff talked about how the birth of a new baby provides hope. Amelia recognized the opportunity that being in Canada provides for her baby. She was anxious to find a job:

> **Amelia:** And I don't miss home too much because this place provides opportunities for my baby. I have to go back to work for my baby and I have to make sure I can give him something to eat.

In Lucy's country of origin, women were not allowed to go to school, so she never learned to read. Lucy expressed a desire to learn to read, have a job, and be able to do the things in Canada that she was previously restricted from doing:

> **Lucy**: I want to go to school. In my country, I was not allowed to go to school. I would like to go to school now. I want to go to school. I want to write, I want to read. Then I can find my job.

One of the focus group participants indicated that many refugees come to Canada for the sake of their children. Some of the women interviewed came from countries where girls are barred from educational opportunities. Canada is a place of hope for the future of daughters, as well as sons:

> **FG:** The other thing is that they came for the future of their children. I mean, even more so now that they know the reality of Canada, which is that they can have a future. A lot of people say that their daughter[s] can do anything they want. There [are] not as many restrictions, and my son can be anything.

Many refugees will do any kind of work because they recognize that, although the benefits of working hard may not be visible in their lives, it will be evident in their children's lives. As one focus group participant indicated, this hope for a better life for children is what enables refugees to do the sorts of jobs that most Canadians would not take:

FG: This is helping their adaptation and they see their children as a part of this society. For one, you are knowledge collectors. You work and put your energy into life and you can do what ever, and it is not demeaning to clean the toilets. You can do whatever for your family's survival and it doesn't matter. They see the advantage of that for their family.

Hope for the future and an ability to find meaning in their children's future gave the refugee women interviewed a focus that enabled them to look beyond the struggles of acculturation and stresses associated with being in a strange country, including a difficult birth experience.

Despite the presence of postpartum depression predictors, the birth of a new baby seemed to operate as a protective factor for refugee women. The birth of a new baby provides a goal and provides meaning for women and their families. The baby is a symbol of making it to Canada, and a successful birth denotes that the family is safe. Bella and her husband were thankful for the safety Canada afforded them: "You see it is very different in our country. Ahh, in Canada it is safe for life." In contrast to their war-torn country, Canada provided safety.

Conclusion

To ascertain whether the difficulties that refugee women face in the postpartum period are serious enough to warrant a diagnosis of postpartum depression, a diagnostic tool would need to account for the larger context of the woman's life, including the method of birth. Because of the open style of interviewing, the participants were able to frame these difficulties within issues that they found significant. The struggles associated with undergoing emergency cesarean section in an unfamiliar environment, and the cultural and social issues that led to those difficulties, were revealed in this study. This study found that refugee women who undergo an emergency cesarean section need more support, both physical and emotional, in the hospital and once they return home.

The interviewed refugee women shared their struggles, but were determined not to see themselves as victims. They saw themselves as survivors of a whole range of difficult and traumatic situations. These experiences, coupled with differences in culture and worldview, make it difficult to apply Western-designed psychometric testing and therapies. Despite the unpleasant experiences surrounding their emergency cesarean sections, they exhibited strength and an ability to survive. Although it was more difficult than necessary, their cesarean section was not their worst experience. This does not minimize the need for refugee women who have had traumatic births to be provided with support services and counselling post surgery. Rather, it indicates that care must be taken when determining the appropriate support services and counselling.

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Printed by Printing Services
University of Saskatchewan • CUPE 1975