

# Exploring the Abortion Experiences of Punjabi Women in Canada: A Qualitative Study

## Thesis

Presented to the Faculty of Graduate and Postdoctoral Studies  
In partial fulfillment of the requirements of the  
Master of Science in Interdisciplinary Health Sciences

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Ottawa, Ontario  
August 2016

## **Abstract**

The research that is currently available on abortion practices among Punjabi women focuses on the phenomenon of sex-selective abortion. To date, there has been no research published on the abortion experiences of Punjabi women in Canada. The objective of this qualitative study is to fill a gap in the literature and shed light on the abortion experiences of Punjabi women across Ontario and British Columbia. Through in-depth interviews with Punjabi women and key informant interviews with health professionals involved in abortion provision, this study documents Punjabi women's abortion experiences in Canada and providers' experiences serving this population. Four Punjabi women and three key informants were interviewed across Ontario and British Columbia. The overall findings suggest that the abortion experiences of Punjabi women are very similar to those of Canadian women, in general. Although none of the participants had undergone sex-selective abortion themselves, women described their perceptions of this practice in the Punjabi community. In addition, Punjabi women suggested improvements in pregnancy options counseling, availability of medication abortion and employment accommodation. Key informants' experiences serving this population differed based on the location of the abortion facility and the demographics of that area. All of the key informants suggested improvements to overcome challenges such as language barriers and newcomer status. Due to the small sample of participants, this study can be considered as a starting point for further research in this area. We hope that the findings of this study can inform improvements in abortion services for this population, as well as shed light on some of the debates underway regarding sex-selective abortion practices.

La recherche qui est disponible sur les pratiques d'avortement chez les femmes punjabi met l'accent sur le phénomène de l'avortement sélectif dans les populations asiatiques. À ce jour, il n'y a pas de recherches publiées sur les expériences d'avortement du femmes Punjabi vivant au Canada. L'objectif de cette étude qualitative est de combler cette lacune dans la littérature et faire la

lumière sur les expériences d'avortement de femmes punjabi en Ontario et en Colombie-Britannique. Par le biais d'entrevues en profondeur avec les femmes punjabi et d'entrevues avec les informateurs clés impliqués dans l'avortement disposition, cette étude documente les expériences d'avortement des femmes punjabi au Canada et les expériences des informateurs clés qui desservent cette population. Quatre femmes punjabi et trois informateurs clés ont été interviewés en Ontario et en Colombie-Britannique. Les résultats suggèrent que les expériences d'avortement des femmes punjabi sont très similaires à ceux des femmes canadiennes en general. Bien qu'aucun des participants n'avaient eux-mêmes l'avortement sélectif, les femmes ont décrit leurs perceptions de cette pratique dans la communauté punjabi. En outre, les femmes Punjabi ont suggéré des améliorations dans les options de grossesse counseling, la disponibilité de l'avortement médicamenteux et l'adaptation des emplois. Les expériences des informateurs clés qui desservent cette population diffèrent en fonction de l'emplacement de l'avortement et la démographie de cette région. Touts les informateurs clés ont suggéré des améliorations à surmonter des défis tels que les barrières linguistiques et statut de nouveau venu. En raison du petit échantillon de participants, cette étude peut être considérée comme un point de départ pour d'autres recherches dans ce domaine. Nous espérons que les conclusions de cette étude peuvent orienter des améliorations dans les services d'avortement pour cette population, ainsi que de faire la lumière sur certains des débats en cours au sujet des pratiques de l'avortement sélectif.

## **Acknowledgements**

I would like to acknowledge Dr. Angel Foster for all her guidance, support, encouragement and kind words throughout this whole process. This project would not be possible without her. Thank you for always going the extra mile, and for always believing in me.

I would also like to give special thanks to Dr. Raywat Deonandan and Dr. Paul Saurette for being members of my thesis advisory committee. Thank you for providing me with insight and guidance during some of the most crucial moments for this project.

I would also like to extend my thanks to all the brave women who have opened up to me about their stories. This project is dedicated to women all around the world who continue to inspire and empower others.

Finally, I would like to thank all the key informants for taking the time to share their professional experiences. Your insight is truly valued and appreciated.

A big thank you to the Society of Family Planning for their generosity in providing the financial resources to make this project possible.

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## **CHAPTER ONE: INTRODUCTION**

### **Background**

Punjab is a province located in the south region of Asia. It was once a united state; however, during the 1947 partition, the land was divided between India and Pakistan (a map of the region is included in **Appendix A**). As a result, the western region of Punjab in Pakistan and the eastern region of Punjab in India have vast differences in culture and traditions. In terms of religion, individuals residing in the Pakistani state of Punjab mostly identify as Muslim, while the majority of those living in the Indian state belong to the Sikh faith (Government of Punjab, 2016). Punjabi is the official language of the state, and it is a shared language spoken by populations in both India and Pakistan. It is the tenth most widely spoken language in the world (Government of Punjab, 2016). The majority of the Punjabi diaspora resides in Canada, the United Kingdom and the United States, as Punjabi-speaking individuals make up a significant percentage of the populations in these countries (Statistics Canada, 2011; United Kingdom Government, 2010; United States Census Bureau, 2013).

### **Abortion in Pakistan**

Abortion is illegal in Pakistan, except in cases where the life of a woman is in danger or where termination is considered a “necessary treatment” early in pregnancy (Guttmacher Institute, 2015). Due to a lack of clarity in interpreting this law, most providers perform this service in secret, making abortion difficult to obtain for women living in Pakistan (Guttmacher Institute, 2015). Given the

secrecy of the practice and the stigma surrounding the topic, women appear reluctant to admit to having sought an induced abortion; thus, most abortion research is conducted from women suffering complications from unsafe abortion (Guttmacher Institute, 2015).

It is estimated that Pakistani women experience about 2.4 million unintended pregnancies annually; of those, approximately 900,000 are terminated through abortion (Guttmacher Institute, 2015). Naveed, Shaikh & Nawaz (2015) suggest that the high number of accidental pregnancies is a result of the low availability and use of contraceptives in Pakistan. This is due to public fear of their side effects, unfamiliarity with their usage and perceived inefficacy of the methods (Naveed, Shaikh, & Nawaz, 2015). Furthermore, there seems to be a correlation between contraceptive use and abortion occurrence in this population. For example, Punjab is the state with the highest contraceptive use in Pakistan, and consequently, has an abortion rate equal to the national; however, Pakistani states with lower contraceptive usage rates have higher than average abortion prevalence (Sathar et al., 2014).

According to the Guttmacher Institute (2015), the profile of an average Pakistani woman seeking abortion services is married with multiple children. Thus, limiting family size can be inferred as an important motivation behind termination of pregnancy in Pakistan. A study by Saleem & Fikree (2001) revealed Pakistani women who had sought an induced abortion listed reasons such as “short spacing”, “too many children”, and “ill health of mother” as their top reasons for termination. Another suggested finding among Pakistani women



is the importance of involving their partners in the decision. Saleem & Fikree (2001) found that the vast majority of Pakistani women identified their husband as the first person they would consult when considering an induced abortion. Very few women believed that they themselves could make an independent decision regarding induced abortion (Saleem & Fikree, 2001).

Another common finding in the literature is the evidence of unsafe abortions in Pakistan. Women seek terminations from professional health care providers and traditional practitioners, both of whom frequently perform abortions under unsafe conditions (Guttmacher Institute, 2015). Sathar, Singh & Fikree (2007) reveal that approximately 197,000 women suffer complications from unsafe abortions annually. In Punjab specifically, an estimated 14 per 1,000 women were treated for complications from unsafe abortions in 2012 (Sathar et al., 2014).

### **Abortion in India**

In contrast with the abortion laws in Pakistan, the Medical Termination of Pregnancy Act (1971) legalized abortion for a broad range of reasons through 20 weeks' gestation in India. According to the Government of India (2013), approximately 600,000 abortion procedures occur annually. This translates to an annual rate of roughly 2 abortions per 1,000 women of reproductive age (United Nations, 2013). However, it is suggested that these numbers are greatly underestimated due to the exclusion of untrained abortion providers in surveys and the systematic undercounting of abortions done by private sector physicians

working in uncertified facilities in India (Stillman, Frost, Singh, Moore, & Kalyanwala, 2014). In addition, these data exclude the use of medication abortion, a method of abortion that allows women to terminate a pregnancy through the use of mifepristone and misoprostol (Stillman, Frost, Singh, Moore, & Kalyanwala, 2014). Currently, mifepristone and misoprostol are both registered and widely available in India (Guttmacher Institute, 2012).

Since medication abortion became available as an avenue for pregnancy termination in India in 2003, studies have shown that most women prefer this method to aspiration/surgical abortion (Tamang, Tuladhar, Tamang, Ganatra, & Dulal, 2012). There is high demand for this service in India, as annual sales of medication abortion pills are estimated to be 11 million doses a year (Kay, 2013). Perhaps this is due to the social stigma surrounding abortion in Indian communities. Banerjee, Andersen, & Warvadekar (2012) found that fear of social stigma was the most common reason why women sought abortion from unsafe providers, or induced abortion themselves. Medication abortion with mifepristone/misoprostol provides a way for women to avoid this stigma and undergo safe pregnancy termination in the privacy of their own homes.

### **Sex-Selective Abortion in India**

A large proportion of the abortion research in India focuses on the phenomenon of sex-selective abortion, defined as termination of pregnancy based on fetal sex. Sex-selective abortion relies on prenatal diagnostic methods such as ultrasound, amniocentesis, and fetoscopy, in order determine fetal sex,

usually during the second trimester (Dickens et al., 2005). Many of the studies on sex selection use birth ratios, which are ratios that are calculated using the number of male births compared to the number of female births in a population. The “normal” birth ratio is cited to be 105 males to every 100 females, or 1.05 (Hesketh & Xing, 2006). Any elevation from this number often argued to be a result of sex-selective abortion in favor of males. Indeed, research suggests that sex-selective abortion may have contributed to the deviation of national sex ratios in India.

A study conducted in India estimated that about 8% of abortion procedures were related to sex selection (Arnold, Kishore & Roy, 2002). Currently, the national sex ratio is 1.12 at birth and there are 108 males to 100 females in the total population, although it is higher in certain parts of India (CIA, 2014). In fact, Ganatra (2008) found that 49 of the country’s 593 districts have a male-to-female ratio of 1.17 or higher. Researchers also suggest that there exist trends involving birth parity, where male-to-female sex ratios increase with higher birth order. For example, Jha et al. (2006) found that the birth ratio was 1.32 for second births with one previous girl and 1.39 for third births with two previous girls in a family. In contrast, the sex ratios were “normal” when the previous child was a boy (Jha et al, 2006). These findings suggest that son preference may play a substantial role in the motivations behind sex-selective abortion. In fact, statistics from India suggest that there are approximately 7.1 million fewer girls than boys aged 0-6 years in the population (Census of India, 2011).

The concept of son preference has commonly been cited as the underlying reason for sex-selective abortion in India, conditioned by both socio-religious and economic factors. First, many religious practices, such as the death rite tradition in Hinduism, are required to be performed by men (Ganatra, 2008). It is important to note here that the literature focuses largely on Hinduism practices and other religious practices are not specified. Secondly, Ganatra (2008) states that many farm-dependent economies in India require male workers, so parents may depend on their sons to financially provide for the family. Furthermore, due to social disapproval of parents residing with daughters, male children are expected to fulfill the role of caretakers for elderly parents (Kulkarni, 2012). Finally, Ganatra (2008) identifies the dowry system as a major factor in the economic disadvantage of daughters.

However, birth ratios are an imperfect method of determining the occurrence of sex-selective abortion, as there exist other methods of sex selection, as well as other factors in general, that may contribute to the national deviation of expected ratios. In contrast to the findings above, a literature review on abortion in India found that “limiting family size” was the most common reason reported by women for having an abortion (Stillman, Frost, Singh, Moore, & Kalyanwala, 2014). In fact, the same researchers found that most second trimester abortions occur for the same reasons as first trimester abortions. These reasons include limitations on family size, spacing of births, financial difficulties, and the social stigma surrounding pregnancy among unmarried women (Stillman et al., 2014). Thus, there are many factors, other than sex selection and son

preference, which may influence an Indian woman's choice to terminate a pregnancy (Stillman, Frost, Singh, Moore, & Kalyanwala, 2014).

Although abortion is legal, there is considerable regulation of sex selection practices in India. Prenatal sex selection was banned in 1994, preconception techniques for the purpose of sex-selection have been prohibited since 2002, and sex selection abortion has been banned since 2003 because of the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act (Ministry of Law and Justice, 2002). Penalties for the use of prenatal and preconception techniques for sex selection include seizure of machines and loss of license for clinicians, and fines and jail time for women (Public Health Foundation of India, 2010). Although overall enforcement of these policies is minimal, various initiatives have been taken by national and state authorities in order to strengthen implementation, such as raids of ultrasound centers in Haryana (Public Health Foundation of India, 2010).

### **Sex-Selective Abortion in Punjab**

In reviewing the current literature on sex-selective abortion in India, a common theme that arises is the prevalence of elevated male birth ratios in the Punjabi population. A study conducted in India revealed that women living in Punjab have a higher odds ratio of giving birth to a male infant in comparison to women living in the other states (Subramanian & Selvaraj, 2009). In fact, Subramanian & Selvaraj (2009) identified Punjab as the state with the highest male-to-female ratio in the country. An earlier study done by Sen (2003) had

similar results, citing numbers as high as 125 males to 100 females in the states of Punjab, Delhi and Gujarat, all areas where a significant part of the population is Punjabi. Finally, Booth, Verma & Beri (1994) reveal that ultrasound was used for fetal sex determination in 6-13% of cases for mothers of boys, compared to only 1-2% of cases for mothers of girls. The research suggests that son preference may be a major concern within the Punjabi community.

### **The Punjabi Population in Canada**

According to the 2011 Census of Canada, Punjabi is the third most spoken language in Canada, as well as the top immigrant language in the nation (Statistics Canada, 2011). Recently, Punjabi was also named the third language of Parliament (Canadian Citizenship & Immigration Resource Center, 2015). However, despite the large population of Punjabi immigrants and Punjabi Canadians in Ontario, there is no research published on the reproductive health of this population. In fact, there are virtually no studies available on the abortion experiences of Punjabi women across Canada. All of the abortion research done in this population focuses on the phenomenon of sex-selective abortion. Thus, it is important to review the current literature that is available surrounding abortion practices in the Punjabi community in Canada.

### **Sex-Selective Abortion and Indian-Canadians**

The research on abortion that is available in Canada does not include the Punjabi community specifically. Rather, this research is focused more broadly

within the Indian immigrant community, and is focused solely on sex-selective abortion. Similar to the birth parity trends in India, Almond, Edlund & Milligan (2013) found that the male-to-female birth ratios significantly increased based on birth order within this population. For example, the researchers reported that the sex ratio for second and third children was 1.19 and 1.90, respectively, for Indian-born mothers residing in Canada (Almond, Edlund, & Milligan, 2013). Ray, Henry and Urquia (2012) found similar trends while comparing the live birth statistics in Ontario; the ratio was 1.36 for second children and 1.25 in third children for Indian mothers. In a more recent study, Urquia et al. (2016) reported that the highest birth ratios in Canada were among two Indian-born parents. In fact, women who had immigrated from India were almost three times more likely than Canadian-born women to give birth to a male child after having previously given birth to two female children (Urquia et al., 2016).

Although these data do not establish the occurrence of sex-selective abortion practices, the skewed birth ratios have led to speculation that these trends are the results of sex-selective abortion. There has only been one Canadian study that has compared these sex ratios to the occurrence of induced abortion. Urquia et al. (2016) found the most pronounced effect on sex ratios in third-order births among Indian-born mothers with two daughters. The researchers revealed that these ratios were significantly higher among Indian-born women who had an induced abortion in comparison to Indian-born women who did not have an induced abortion prior to the third-order birth (Urquia et al.,

2016). Interestingly, an induced abortion among Indian-born women with two sons was extremely uncommon (Urquia et al, 2016).

### **Study Rationale**

A review of the current literature reveals that there has been no research done to date on Punjabi women's experiences obtaining abortion services in Canada. The aim of my thesis is to fill a gap in the literature through a qualitative study that documents both abortion providers and Punjabi women's experiences with abortion. I aim to shed light on, and understand better, the experiences of Punjabi women with abortion care in Canada. Documenting Punjabi women's abortion experiences more broadly allows for examination of how issues related to language, immigration status, and discrimination might be impacting the abortion care that women receive. As well, exploring Punjabi women's and key informants' perspectives on the phenomenon of sex-selective abortion allows for a better understanding of the practice itself. Finally, this study explores the opinions of both Punjabi women and abortion providers on how services could be improved in Canada.

### **Research Objectives**

As shown by the literature review and background information, there is no research available on the general abortion experiences of Punjabi women across Canada. Rather, the focus is on presumed sex-selective abortion practices within minority Indian immigrant populations. In contrast to laying blame on or



stigmatizing these populations, this study is motivated by a desire to understand Punjabi women's experiences with obtaining abortion care and providers' experiences serving this population. Through in-depth interviews with Punjabi women and semi-structured interviews with key informants, this project aims to address the following questions:

1. What are Punjabi women's experiences with obtaining and receiving abortion care in Canada?
2. What are the experiences of abortion providers in Canada serving Punjabi women?
3. In what ways could abortion care be improved for Punjabi women in Canada, from the perspective of both the providers and the Punjabi women themselves?

## **Thesis Outline**

I have written this thesis using a thesis-by-monograph approach. This thesis is divided into five chapters, outlined below:

1. Chapter one is the introduction, and provides background information on the Punjabi population in general, as well as the current abortion research available on this population. This chapter also contains the study rationale, the study objectives, and the thesis outline.
2. Chapter two provides a detailed explanation of, and the reasoning behind, the methodological approach used for this study.

3. Chapter three includes the results from the first component of the study, the in-depth interviews with Punjabi women across Canada.
4. Chapter four includes the results from the second component of the study, the key informant interviews with abortion providers serving Punjabi populations across Canada.
5. Chapter five, the final chapter, summarizes the findings of this study in relation to the current information available on abortion practices within the Punjabi population in Canada. This chapter also includes the significance and implication of the findings, study limitations, future research directions and the conclusion. This chapter is followed by the bibliography and several appendices.

## **CHAPTER TWO: METHODOLOGY**

Given the lack of data on women's actual abortion experiences in the literature, we decided that a qualitative approach would best allow us to address our research questions. In order to encompass all aspects of women's experiences with abortion care, we decided to divide this study into two components. The first component was dedicated to documenting Punjabi women's experiences with abortion in Canada. For this, we conducted in-depth interviews with Punjabi women. The term "Punjabi woman" was defined as an individual who identified as ethnically Punjabi, regardless of nationality or immigration status. For the second component of the study, we conducted key informant interviews with abortion providers who had experience serving Punjabi women in Canada. We focused on recruiting participants from Ontario and British Columbia, as these two provinces contain the largest populations of Punjabi-speaking individuals in Canada (Statistics Canada, 2011).

### **In-Depth Interviews with Punjabi Women**

For this component of the study, I conducted in-depth interviews with Punjabi women who had obtained abortion care in either Ontario or British Columbia. I invited Punjabi women who had an abortion in the last 10 years to participate in a 90-minute interview. Additional eligibility criteria included being age 18 or older, being sufficiently fluent in either English or Punjabi in order to complete the interview, and having access to a telephone or Skype for communication purposes. I translated all interview materials into Punjabi, and I

conducted the interview in the language of the participant's choice. As well, I offered all participants a CAD40.00 Amazon gift card as an incentive for participation and a thank you for their time.

### *Recruitment*

I employed a multi-modal recruitment strategy to identify participants. First, I continuously posted online advertisements for the study, primarily on Kijiji. The ads included a short description of the study, eligibility requirements, and contact information for questions and information about the project. I also created a website specifically for the study, which contained detailed information about the research project. I then shared this information through various social media platforms, such as Facebook and Twitter. A major component of recruitment was through networking with community organizations. I e-mailed information about the study to various reproductive health, abortion and reproductive rights, and South Asian organizations based out of Ontario and British Columbia. Many of these organizations then spread this information by way of social media or by posting study flyers.

For Ontario specifically, I distributed study flyers in Ottawa and Toronto, due to the relatively large population of Punjabi-speaking individuals in these areas (Statistics Canada, 2011). I also posted flyers in neighborhoods with a high proportion of South Asian businesses, such as ethnic grocery stores, clothing shops, jewelry shops, and restaurants. Travel to British Columbia for flyer distribution was not possible, due to the long distance. Instead, I provided

information about the research project to CJSF, a radio station based out of Burnaby, British Columbia. CJSF then aired a public service announcement regarding the study.

### *Intake Interviews*

Once women had expressed initial interest in the study, I scheduled a 5 to 10 minute intake interview at their convenience. The purpose of this telephone or Skype interview was to provide more information about the project, ensure that the women were eligible for participation, and answer any questions about study. I began the telephone call with a detailed description of the study. I then asked participants a series of questions related to age, ethnic background, and the actual abortion procedure, in order to ensure that they were indeed eligible to participate. Once they were deemed eligible, I gave participants the option to schedule a 90-minute telephone or Skype interview in the language of their choice. After it was scheduled, I sent a follow-up e-mail to participants, with the confirmed date and time of the interview, as well as a copy of the consent form.

### *In-Depth Interviews*

Before every interview, I obtained verbal consent from the participant. The interviews began with questions related to the participants' general background and demographics. Then, the interview transitioned to questions about reproductive health history before turning to the participants' abortion experience(s). I then asked women to discuss the circumstances surrounding the

pregnancy that was terminated, factors influencing decision-making, and the general process of obtaining abortion care. I also asked participants about their experience(s), if any, with sex-selective abortion in the Punjabi community, and their own perspectives on the practice. Finally, the interview ended with a discussion of ways in which abortion care could be improved for Punjabi women in Canada, as well as questions about the medication abortion pill mifepristone. After the interview, I e-mailed a CAD40.00 Amazon gift certificate to all participants.

### *Study Design*

The design of this study was informed by the Canada Abortion Study, a large-scale qualitative study dedicated to documenting women's abortion experiences throughout Canada. Based on that study, I anticipated needing 20 to 30 interviews in order to reach thematic saturation on my stated research questions.

### **Key Informant Interviews**

For the second component of the thesis project, I conducted telephone or Skype interviews with abortion providers and those involved with abortion provision in Ontario and British Columbia. I defined key informants as health professionals who had experience providing abortion care or counseling to the Punjabi community, including physicians, nurses, counselors and community stakeholders. Interviews averaged around 20 to 30 minutes in length.

Participants were not compensated for their time; however, I offered all participants a final report on the study findings.

### *Recruitment*

In order to recruit for this component of the study, I developed an invitation letter addressed to key informants. This letter contained details about the study and contact information for the study team. I then e-mailed this letter to various community health organizations, sexual and reproductive health clinics, abortion clinics, and family medicine clinics in Ontario and British Columbia. As well, I contacted the organizers for various health-related conferences and requested that they distribute my invitation letter to any key informants who were attending the event. Finally, similar to recruitment for the in-depth interviews, I had the opportunity to participate in a radio interview on CJSF in British Columbia. Information about the study and the research team was broadcasted with the aim of recruiting key informants in the British Columbia area.

### *Interviews*

Once key informants had expressed interest in participating in an interview, I scheduled an interview at their convenience. I e-mailed all key informants a copy of the consent form prior to the interview date, and then obtained their verbal consent at the beginning of each interview. The interview began with the key informants' general background and employment history. I then asked questions about their experiences providing abortion services to the

Punjabi community. The interview then transitioned to questions aimed to explore abortion providers' perspectives on sex-selective abortion, both in general and among Punjabi women in particular, their experiences providing abortion care in these circumstances, and their opinions about efforts to regulate and/or ban the practice. Finally, the interview ended with a discussion of ways in which abortion provision could be improved for Punjabi women in Canada. In order to obtain a range of perspectives, I expected to conduct 10 to 20 key informant interviews.

### **Data Analysis**

With the consent of participants, I audio-recorded all in-depth interviews and key informant interviews. I took notes during each interview and engaged in formal memoing after each interview, in order to reflect on both the content of the interview and my own subjective influences on the interaction. Following data collection, I transcribed all of the interviews in order to prepare for the process of data analysis.

I then analyzed the transcribed data for content and themes and used ATLAS.ti software to manage the data. I developed a codebook for the transcripts using both *a priori* (pre-determined) and inductive codes. Initially, I reviewed the in-depth interviews and key informant interviews separately. At a later stage in the analytic process I compared the findings from the two components in order to identify concordant and discordant themes for each component of the study. Following this process, I was able to identify key themes and relationships between the interviews and assign meaning to the data.



## **Ethical Considerations**

The two components of this research project received approval from separate Research Ethics Boards at the University of Ottawa. After submitting a modification request under the Canada Abortion Study, we were able to receive expedited approval for the in-depth interview component of the study from the University of Ottawa Research Ethics Board (File #H08-12-08). We received approval for the key informant interview component of the study from the Social Sciences and Humanities Research Ethics Board (File #03-15-29). Both letters of approval are included in **Appendix B**.

## **CHAPTER THREE: IN-DEPTH INTERVIEW RESULTS**

### **Participant Demographics**

There were a total of four in-depth interview participants. One of the participants had obtained abortion services in British Columbia and three of the participants were living in Ontario at the time of their abortion. The participant from British Columbia had opted for a medication abortion procedure (with methotrexate/misoprostol), while the three other women had undergone aspiration/surgical abortions. At the time of the procedure, most of the participants were between the gestational ages of 6-8 weeks, while one participant had a second-trimester abortion at 14 weeks. All of the women who were interviewed had one abortion procedure within the ten years prior to the interview.

The majority of the participants were 25 or older, with one participant between the age of 18 and 24. Three of the participants were born in India and the other participant was born in Canada. Two of these participants had immigrated to Canada at a very young age, while the remaining participant had immigrated when she was over the age of 18. One of the participants was married, and she was the only woman who previously had children. The rest of the women had only been pregnant the one time. All four of the participants had obtained at least some post-secondary education, through community college or university. Finally, three out of the four participants were currently employed.

### **Reproductive Health History**

### *Wide range of reproductive health experiences*

When asked about their reproductive health status overall, all of the women self-reported to be in good or excellent health. When asked about current problems or conditions, responses included irregular or painful periods, fertility issues and urinary tract infections. Women were also asked to describe the most important reproductive health events that had occurred in their lifetimes, and they often listed events that had impacted their health status during some point in time. The most common responses were their first period and their abortion.

### *Comfort and trust remain factors in choosing to see a physician*

All of the women reported having a family physician. The perceived relationship women had with their family doctors directly affected where they chose to obtain services for their reproductive health. A good relationship was described as one where a woman was comfortable discussing her health issues with her family physician. The women who described having good relationships with their family doctors had sought reproductive health services directly from them. Meanwhile, some women were uncomfortable going to their family physician for their reproductive health needs. These women chose to obtain services from walk in clinics or other health care facilities instead.

When these participants were asked about why they felt uncomfortable with their family physicians, they gave a number of reasons. One woman did not feel comfortable talking about her reproductive health with a male physician. Another issue was the sense of judgment that one woman felt while obtaining

birth control services from her family doctor. Finally, one woman described the importance of confidentiality in the physician-patient encounter.

My family doctor is the same doctor for my sister, my parents and I. And the nurse practitioner that works for him is a part of the [Punjabi] community... So I didn't feel comfortable because I felt like it wouldn't stay as confidential.

– Participant #4

### **“I’m Pregnant!”**

#### *Contraceptive use prevalent among women*

For all of the women interviewed, the pregnancy that was terminated had been unplanned, due to either failed contraceptives or lack of contraceptive use. Among the women who were on contraceptives, two of the women were using condoms, while one woman had an intrauterine device (IUD). Only one of the participants was not on any form of contraceptives at all at the time of the unintended pregnancy.

#### *Symptoms were main indicators of pregnancy*

All of the participants suspected pregnancy once they had missed their period. All four women had decided to take a pregnancy test after experiencing some sort of change in their bodies. One woman described having frequent headaches, difficulties eating and sleeping, and feeling tired and sore. Another woman experienced light bleeding and heartburn. Finally, one woman stated that she had nausea and vomiting.

### *Pregnancy timing is an important factor*

Women were asked about their feelings regarding pregnancy prior to finding out that they were pregnant. Out of all the women interviewed, only one woman was at a point in her life where she no longer wanted kids. This was because she already had children at the time of the unintended pregnancy. The rest of the participants eventually wanted to start a family. However, all three of these women stated that due to the circumstances surrounding the pregnancy, it was simply not the right time for them. It was common to hear phrases such as:

It's just not how I imagined myself to be pregnant.

– Participant #2

I always thought my pregnancy would come at a time where I was ready.

– Participant #4

Participants considered the responsibility a woman has while dealing with an unintended pregnancy. While weighing her options, one participant contemplated on how she would have to undergo changes in her career, her family, and her body if she were to carry through the pregnancy to term. Due to their individual circumstances, many participants felt that it was the wrong time for these changes to occur.

### **The Decision-Making Process**

*Feelings of uncertainty are rare*

Once they had found out they were pregnant, women were asked about what options they had considered. There was only one woman who had contemplated continuing the pregnancy to term and parenting. This same participant was the only woman who had visited a counselor before making her decision. The three other participants had not visited any counselors, clinicians or agencies prior to their abortion procedure. These participants stated that they had immediately come to the decision to terminate. After having made this decision, they stated that they were 100% certain of their decision.

I just knew immediately that was the right thing to do for myself and my partner...I wasn't really like, "Which one am I going to choose to do? What is the right thing to do?" It was more like, "I know I have to do this.

– Participant #3

#### *Health, marital and financial status are important factors*

Women indicated that a wide range of factors had ultimately led to their decision to have an abortion. Some women described feeling worried about their ability to take care of a child. One participant stated that she suffered from health issues that had already made it difficult to take care of her current children. As such, she did not feel like she could handle the responsibility of another child. Another woman expressed similar concerns, stating that she was unsure of whether she was in a good state of take care of a baby.

A common finding among women seeking termination was the stability of the relationship with their partner. There was a lot of importance placed on their marital status. Three out of the four participants described the desire to be

married before having a child. These same participants also expressed the importance of living with their partner before having a baby.

And he always wanted to have kids, and I just told him, “No, I want to be married before I start a family.” And he only had one friend who got married before he had children and the rest are still with their partners, but they have children out of wedlock. And that’s fine, there’s nothing wrong with that, but it’s not what I wanted.

– Participant #2

Another common finding among women seeking an abortion was the importance of financial stability. First, women were worried about their employment situation. One participant expressed worry over her unstable job position, as well as the lack of benefits from her partner’s workplace. Another participant stated that her partner did not have a job at the time. These women expressed the desire to have a stable income in order to be able to afford the expenses of a child. Second, one participant in particular stated that her living arrangements were simply too small to accommodate a child. She felt that she needed to move to another place before having a baby. Finally, two of the participants were still in school at the time of the unintended pregnancy. These women felt that they could not afford to have a child as their finances were being allocated to educational expenses.

Financially we didn’t know how we would work things out. Obviously that’s a huge commitment, and we can barely take care of ourselves financially at this point, just because we are both in school and paying our way through school. We just wanted to provide a better quality of life for ourselves if we were to have a child, just to have more stability.

– Participant #3

### *Family support and cultural stigma influence decision-making*

When asked about factors that influenced their decision, women described the importance of family support. One participant shared an in-depth story of her family situation. This woman's parents disapproved of her partner, and this had created conflict within the family. She had decided to keep her pregnancy a secret from her parents, as she felt that this would have aggravated the situation and led her parents to refuse speak to her. She stated that the circumstances within her family had definitely played a role in her decision to terminate her pregnancy. Similarly, another participant expressed worry over the lack of support she would have received from her family, had she told them about her pregnancy.

I just feel like I wouldn't be able to go through with everything on my own, just because I didn't have the support from my family. Their reactions would have been worse than anything.

– Participant #4

Some of the participants also suggested that the stigma of pre-marital pregnancy in Punjabi culture had been a factor in their decision-making process. One participant described how she would never been able to keep the pregnancy as an unmarried woman in the Punjabi community. This woman felt it would have been extremely stigmatizing and she would have been labeled. Another woman discussed the taboo of pre-marital sex and abortion in Punjabi culture.



I think there's definitely more that needs to be done to tackle the taboo of girls having an abortion... so that if girls do accidentally get pregnant, making it more comfortable for them to have the baby or feel supported by the community. And maybe that was a factor in my decision, like, "What are people going to say?" and all those types of questions.

– Participant #2

## **Women's Abortion Experiences**

### *Contentment with availability of abortion services*

After they had made the decision to terminate, women contacted local health care providers for an appointment. Most women were content with the fact that they were able to get an abortion appointment within the week. The remaining participant had to wait two weeks for an appointment. She described feeling stressed about the two-week wait time, as she wanted to have the procedure done as soon as possible. However, despite the stressful wait time, this woman expressed appreciation towards the fact that abortion was an available choice.

I thought that it's a good thing that in Canada we have that. That you're able to choose what you want to do instead of having to go through, I don't know, maybe an underground place, in some countries... you know?

– Participant #1

### *Identical experiences on the day of the appointment*

Participants were asked to share their experiences on the day of their abortion procedure. All of the women described a similar sequence of events. First, women were asked to check in after being dropped off, taking public

transportation or taking a taxi to their appointments, as they were told not to drive. This usually involved giving the administrative staff their provincial insurance card, as well as filling out some paperwork. Two of the participants had the entire abortion at no cost, while one participant was required to pay for the counseling session and another was required to pay for her medication.

Afterward, all of the participants were constantly going back and forth in the waiting room while receiving pre-procedure care from the staff. During some point in the appointment, participants were asked to change into a gown. All of the participants also had an ultrasound done at the clinic in order to confirm how far along the pregnancy was. In addition, all of the participants were required to attend a 30 to 60 minute counseling session prior to their abortion procedure. Some of the participants were then given medication before going in for the abortion procedure.

Three of the four participants had an aspiration/surgical abortion procedure done at the clinic. This procedure typically lasted between five and fifteen minutes. After some time spent in recovery, the participants were then permitted to leave the clinic. The participant who had opted for a medication abortion used a combined regimen of methotrexate and misoprostol. The physician had given her a methotrexate shot at the clinic, and then she had taken the misoprostol pills at home. The medication abortion process had lasted one day. The participants had all spent a total of one to one and a half hours in the abortion clinic.

When asked whether the abortion clinic had offered follow-up care or post-abortion resources, all of the women stated that they were told to follow up with a family physician. None of the women had suffered major side effects from their procedure. Women did report experiencing bleeding and cramping, hallmarks of the abortion process, and minor and transient side effects, including nausea, vomiting, and body aches and pains.

*Informational counseling is considered beneficial*

During the counseling session, women described a similar sequence of events where the counselor would discuss their feelings about the decision, information about the abortion procedure, and contraception plans going forward. Women were asked whether they considered the pre-procedure counseling to be helpful. Two of the participants responded that this counseling session was a good outlet for their emotions. One woman stated that the counseling session helped her realize she was not yet ready to make a decision regarding her pregnancy, and she ended up cancelling her abortion appointment that day (she made another appointment once she had finalized her decision to terminate). Another participant stated that it was helpful having a counselor that was very knowledgeable about the procedure. Finally, one woman stated that it was useful to learn about taking precautions in order to prevent unintended pregnancy.

Some women also listed negative aspects of the counseling session. One participant felt confident in her decision and calm during the appointment. However, she felt as if the counselor would not accept that she was so calm

during these circumstances. She stated that the counselor kept on asking her questions about grief and coercion, which were completely irrelevant to her situation. Another participant described a similar experience, where she did not find the counseling session useful since she was already confident in her decision to terminate. However, both of these participants appreciated the abortion and contraceptive information provided by the counselor.

*Compassion and consideration are important qualities among clinic staff*

When women were asked about the care they had received at the abortion clinic, three participants described a lack of compassion among the staff. One participant felt that the staff should have displayed more sympathy to the patients, and she had perceived them to be judgmental. Two other participants described experiences where they felt rushed. These women stated that the abortion care happened fairly quickly and abruptly, without much time given to each patient. The two women also stated that their interactions with the staff were very to the point, and this had bothered them as they expected more detail and explanation. One participant described her interaction with a clinic physician in the following way:

“But it would just be nice if there were more care from the doctor, because afterwards I also didn’t know what to expect. I didn’t know how much pain I was going to be in. I didn’t think to ask those questions, but it just would have been nice to have the doctor discuss that with me.”

– Participant #3

Another issue brought up by two participants was the lack of consideration displayed towards the patients. For example, one woman stated that she had been in a very emotional state while in the waiting room, and the staff had been casually chatting about their weekend. She felt that they should have been more considerate toward the feelings of patients in the waiting room. Another woman stated that there should have been more emphasis placed on the confidentiality of patients. She suggested that clinic staff should not talk about patients in an area where others are able to hear. She felt bothered by the fact that her name and age was said out loud, in front of the other patients. In terms of positive qualities among the staff, one participant appreciated the fact that there were a lot of female staff members. Two of the women also described the clinic staff as supportive, nice, non-judgmental and professional.

#### *Protestors evoke negative emotions*

One woman had encountered abortion protestors outside of the clinic on the day of her appointment. She described feeling “scared and nervous” as they handed out flyers. Although none of the other three participants saw them on the day of their appointment, one woman stated she had frequently seen abortion protestors on the highways. She described the images they had displayed as “traumatizing”. The women who had not encountered protestors outside the clinic attributed this to the nondescript appearance of the facility.

#### *Feelings of regret are rare*

Participants were asked about their emotional status before, during, and after the abortion procedure. Pre-abortion procedure, women described feeling “worried” or “nervous”, as they did not know what to expect. Some participants brought up the fact that the procedure was at first, “scary”.

Immediately after the procedure, women described the procedure using words such as, “clean”, “quick” and “simple”. Some women described dealing with difficult emotions after the procedure. One of the participants stated she felt “grief” and “emptiness”. A second participant explained that it was difficult for her to see pregnant women and families with young kids. On the other hand, two of the participants described feeling “relief” once the abortion process was complete.

Women were then asked to reflect on their abortion experiences and describe their feelings in the current moment. Two of the participants stated that they felt confident in their decision. The two other women stated that they often wondered how their life would be different if they had chosen another option; however, they ultimately felt “okay” or “good” about their decision and would not have chosen a different option.

### *Social support is valued during the abortion process*

All of the participants reported having a strong support system. Women identified their partners, parents, children, siblings and friends as their main sources of emotional support. These same people were the ones women consulted during the decision-making process. In addition, when asked if there

was anything that they would have changed about their abortion experience, some women stated that they would have chosen to bring someone to their appointment rather than going alone. This finding suggests the importance of social support throughout abortion process.

### **Sex-Selective Abortion**

#### *No participants considered sex-selective abortion themselves*

Women were asked if they had ever heard of any media coverage on the topic of sex-selective abortion. Two out of the four participants stated that they had seen some stories, mostly documentaries or media pieces focused on the Indian community. When asked about their thoughts on this media coverage, and sex-selective abortion in general, all of the participants either stated that they did not agree with the practice or they personally would not choose to do it. A common statement among women was that the sex of the newborn child should not matter.

It's not right... I can't see [how] the person who really wants to have a son... how they're feeling about it, but for me, I feel like there's no difference between having a daughter or a son.

– Participant #1

#### *Punjabi women were open to finding out the sex of the fetus before birth*

Similar to many other demographic groups across Canada, participants suggested that Punjabi women were interested in identifying prenatal fetal sex. In the discussion surrounding sex-selective abortion, a common theme that arose

was prenatal sex determination. However, one participant suggested that fetal sex determination was done for reasons other than sex selection.

I don't know anyone that's actually gone through it, but I know a lot of people that do have the sex checked before to decide if, for instance, they'd want to celebrate the child's birth.

– Participant #4

*Some participants acknowledged that son preference may exist to some degree*

Another theme that arose during the discussion about sex-selective abortion was the concept of son preference within the Punjabi community. Two women described instances where someone they knew was disappointed with the birth of a female child. Participants suggested reasons for why some families might place more value on male children. One woman was told that because daughters leave the home once they get married, sons are considered the caretakers for parents in old age. This participant also mentioned that she had heard it was important to have sons for land and property inheritance. Another participant also reiterated the importance placed on having a male heir and passing on the family name.

I do feel like it is the older generation that the legacy of a family can only be carried down through males. So a lot of Punjabi families feel like if they don't have sons that their actual legacy won't be carried on. It comes from a lot of the gender segregation within the community.

– Participant #4

*Little evidence of sex-selective abortion in participant's social circles*



Participants were asked if they had heard of any instances of sex-selective abortion among their community. Although none of the participants could provide first hand knowledge of a situation, two women described their perceptions of this practice in the Punjabi community. One of the participants described that she had heard of instances where women in India had ultrasounds for fetal sex determination prior to having abortions. Another participant stated that she knew a Punjabi woman who had travelled to India in order to get an ultrasound done every time that she was pregnant, supposedly for sex selection purposes. It is important to note that these participants' perceptions of the community cannot be considered evidence for sex-selective abortion itself.

### **Improvements in Abortion Provision**

#### *Clinic atmosphere affects abortion experience*

All four of the participants would recommend their abortion facility to other women seeking abortion services. Two participants explained that it was because they were able to get a quick appointment and the process was easy. One participant would recommend the abortion clinic based on how everything was handled in a discrete manner. Two women also mentioned that the staff was “professional and non-judgmental”, and this had made them feel comfortable. Finally, one woman explained that the facility she went to was very “clean” and “spacious”. These responses suggest the importance of availability and access of services, staff conduct and clinic appearance, all of which have significant effects on the atmosphere of the clinic.

Women felt that the atmosphere of the clinic was an important aspect of their experience. Participants wanted to feel comfortable in the facility they had chosen for their procedure. One woman felt that her strict and unsympathetic interactions with the staff made the clinic feel like a “jail”. Another woman felt that the restricted amount of space in the facility took away from the privacy of the clinic. Another participant also mentioned the importance of privacy during the abortion experience. She described walking down a hallway and seeing an open door to a room, in which a woman was crying. This experience had left her feeling extremely uncomfortable. These women suggested that adjustments be made to clinics in order to make the atmosphere more inviting and discrete.

#### *Need for comprehensive pregnancy options counseling*

In terms of counseling, two participants suggested that family and walk in clinic physicians be more knowledgeable about pregnancy options. These women stated they would have benefitted from either more comprehensive counseling from the initial physician they had seen, or from receiving additional pre-abortion counseling resources from these doctors. The two participants felt that this counseling was presented to them at the wrong time, as they had already made their decision at the time of the pre-procedure counseling session at the abortion facility.

I guess when I felt like I needed someone to speak to, there wasn't anybody really. And then at the time when I'd already made my decision, I felt pretty confident in it. I didn't feel at that time that I

needed the counseling session. It's that moment when you find out that you're like, "Okay, well, what am I going to do now?"

– Participant #3

#### *Need for availability and financial coverage of medication abortion*

The participant that had opted for a medication abortion did suggest some improvements in provision. First of all, she had to pay for the medication up front, which she was later reimbursed for. She could see the cost of the medication being a barrier for some women. As well, this clinic was the only one in her area that provided medication abortions, and it was quite far for her. When she was required to go back to the clinic for a follow up appointment, she found this to be uncomfortable, as she was taking public transit and was in a considerable amount of pain. It would be beneficial to have more clinics providing medication abortions, or having clinics in locations accessible by all residents of an area.

#### *Need for employment accommodation*

Three out of the four women had taken time off work in order to accommodate the abortion procedure. The participant who had undergone a medication abortion did not miss work, as she had scheduled her appointment on a Friday that she was off and recovered over the weekend. This woman stated that she had not taken time off because her workplace was busy during the time of her abortion. She felt uncomfortable asking for time off, as her employers would have asked for a reason or for a doctor's note. Another participant expressed similar views, stating that she should have been able to provide a doctor's note to her employer for time off; however, she could not have done so

without providing a reason. It would have been beneficial for them to be able to take time off without being required to provide their employer with reason. One woman also suggests the need for accommodation because of recovery time.

I feel like there should be more support towards the women who have their abortions done. From not just the abortion clinic, but also the workplace, like time compensation and stuff. Because I have friends who have had abortions and fallen into depression after, and they weren't really given any exemption from work because of it.

– Participant #4

## **Medication Abortion and Mifepristone**

### *Preference for surgical abortion*

Out of the four participants, three women had expressed preference for surgical abortion. One woman stated that she was afraid of the bleeding that came with medication abortion. As well, she was afraid of undergoing an abortion procedure on her own, without the supervision of medical professionals. Another participant said she knew what to expect for surgical abortion, whereas for the medication abortion, she would be worried about how the outcome of the process. The last participant had actually undergone a medication abortion, and afterwards stated that she would have preferred the surgical. She stated that the medication abortion was painful and the process felt prolonged. She would have preferred the shorter amount of time it took with the surgical procedure.

Alternatively, the participant who would have preferred medication abortion listed a number of reasons why. First of all, she would have liked to have her abortion procedure done at home. Secondly, she stated that it would

have saved her a lot of time. She would not have taken the time off work for the abortion appointment. Finally, she would have preferred medication to the invasiveness of an instrumentation abortion. The participant who did undergo medication abortion stated that she chose the procedure for a similar reason. The medication abortion procedure simply sounded “less scary” than the surgical procedure.

*Mifepristone is considered to be beneficial*

Two of the participants had heard about the abortion pill mifepristone. When asked about their thoughts on the medication, two women expressed similar views on the benefit of taking the pills orally, rather than having something inserted vaginally. One participant felt that a drawback of the medication was the fact that the actual abortion procedure could last a couple of days. In her opinion, it was too much of a time commitment. Women were also asked how they would feel about receiving the abortion pill from their family physician and/or a nurse practitioner. All of the participants stated that this would not bother them. One woman stated that she would have preferred receiving abortion care from her family physician, as would have felt less anxious about the procedure. Another woman stated that since she did not have a good relationship with her family physician, she still would have opted to see another doctor for her abortion care. However, she could see the benefit of mifepristone for instances where mobility was a barrier in accessing abortion care.

## **CHAPTER FOUR: KEY INFORMANT INTERVIEW RESULTS**

### **Participant Information**

There were a total of three key informant interview participants. One of the key informants worked in British Columbia, while the other two key informants provided services in Ontario. One of the participants worked at a facility that offered sexual and reproductive health information to the community. This participant provided pregnancy options counseling to women seeking termination. Another key informant worked at two facilities that offered abortion care, contraception, and counseling services. This participant was a nurse who provided counseling to women who came in for abortion procedures. The third key informant worked at two facilities that offered abortion and contraception services. This participant was a physician who provided surgical and medication abortion care to patients.

### **Experiences Serving Punjabi Women**

#### *Abortion circumstances are similar across ethnicities*

One participant stated that the reason for termination brought up most often was financial concerns, and this was the same across women of all ethnicities. This participant also mentioned that it was common to see women choosing to terminate a pregnancy based on inconvenient timing due to still being enrolled in school. This participant stated that Punjabi women that came in seeking abortion care described similar circumstances to non-Punjabi women.

A lot of the times the individuals that I am working with explain stories that I have heard many times. This isn't the right time in their life, that if circumstances were different that they might consider a different option, and that right now they just need our assistance to help them with the termination.

– Key Informant #1

Another participant stated that Punjabi women often came in requesting termination due to not being in a relationship with a partner at the time. In addition, many women sought termination because they felt they were too old to be having a baby. Finally, this participant stated that her experience providing services to women with unintended pregnancy was very similar across lifespan, as well as ethnicity. These findings suggest that there are no significant differences in the reasons why Punjabi and non-Punjabi women access abortion.

#### *Family and timing shape Punjabi women's abortion decisions*

Key informants were asked about whether they had encountered anything unique about Punjabi women while serving this population. Two key informants described how Punjabi women were more likely to involve their partners and their families in the decision-making process. Punjabi women were also more likely to come in with family members in comparison to women of other ethnicities. In addition, Punjabi women were less likely to never want children compared to non-Punjabi women, suggesting that having a family was culturally important. One key informant noted that the precise timing of having children was important to Punjabi women and their families. Another participant reiterated this finding,

stating that women often described circumstances where the timing was wrong for having another child, as they had just given birth within the last year.

Many of them will be saying, “Not this year, next year.” And that I find a little less common amongst non-Punjabi women, who more likely having an abortion will say, “We can’t start having a family for years”... So the precise timing of their family seems to be important, in an interesting way.

– Key Informant #3

### *Service access is related to area demographics*

Two key informants stated that they provided services to Punjabi women daily, while one key informant stated that Punjabi women accessed their services once a week, on average. When asked to compare Punjabi women’s service access to women of other ethnicities, all of the participants stated that it was consistent with the demographics of their area. Key informants who worked in an area with a large Indian population saw more Punjabi women in comparison to non-Punjabi women, while those employed in areas where Indian individuals were a minority population did not see Punjabi women as often as non-Punjabi women. Key informants were also asked if there was an increase or decrease in service access over the years; again, they stated that service use was consistent with population demographics. If there was an increase of Punjabi women living in the area, there was an increase in service access, and vice versa. Typically, Punjabi women came in requesting pregnancy options counseling or abortion care.



### *Possible aversion to hormonal contraceptives and Punjabi health professionals*

When talking about factors that set Punjabi women apart, one key informant described preferences unique to her Punjabi clients. In terms of contraception, one participant noticed that Punjabi women were less likely to take hormonal contraceptives. This participant described instances where women expressed reluctance due to the weight gain or other side effects associated with hormonal contraception. The same key informant noticed that the women she served often avoided interaction with the Punjabi health professionals at her facility. She suggested that this was because women feared judgment from them.

We had a [health professional] who was also Punjabi... born in India. And my manager thought that when Punjabi women came in... it would be great to have a [health professional], who could talk to them in Punjabi... But actually, that was not a good thing, because we started noticing that the patients... wouldn't want to talk to this other [health professional] who was actually from India.

– Key Informant #2

### **Sex-Selective Abortion**

#### *Punjabi women were open to finding out the sex of the fetus before birth*

Two participants also described instances where it was common for Punjabi women to request prenatal sex determination. One key informant described that it was very common for women to request fetal sex determination during counseling. Since this service could not be provided to them at the facility, women would request information about where they could get an ultrasound performed for sex determination. Another participant stated that a desire to know fetal sex was more common in all of her Asian clients. However, she also stated

that many women had sex preferences regarding their pregnancies, so this was not exclusive to the Asian population.

*Providers have differing experiences with sex-selective abortion requests*

Participants were asked whether they had ever encountered any circumstances where an abortion was requested for sex selection purposes. Two key informants had not encountered any circumstances where an abortion was requested for sex selection. The other key informant stated that Punjabi women often came into her place of work in order to request sex-selective abortions. This participant explained that during counseling sessions, women would explicitly state sex selection as a reason for why they were seeking pregnancy termination. This key informant suggested family pressure as a common motivation behind sex-selective abortion, as she often encountered Punjabi women describing circumstances where a family member desired a male child.

Another participant described that she knew of a facility across the border in the US that provided fetal sex determination to patients seeking abortion services. The key informant described the facility as “unscrupulous”. She stated that patients were told the fetus was female in all cases except when it was very obviously male, resulting in abortion of both male and female fetuses. This participant felt it was unfortunate that these women were not being given accurate information. It is important to note that conclusions regarding sex-selective practices cannot be drawn from this information, given the distinct experiences of each provider.

*Providers are aware of the discussion over sex-selective abortion*

Key informants were also asked whether they had heard of any media coverage on the topic of sex-selective abortion. Two of the participants stated that they had seen written pieces or political debates discussing sex selection. When asked about their thoughts on this discourse, one key informant stated that she felt everybody had the right to their own opinion and it was beneficial for Canadians to have discussion on such topics. Another key informant explained that she did not see any difference between having an abortion for sex preferences and terminating a pregnancy for partner or timing preferences.

*Key informants strongly support abortion access; have varying opinions on the regulation of sex-selective abortion*

Finally, participants were asked about their thoughts on efforts to regulate or ban the practice of sex-selective abortion. One participant expressed agreement with these efforts. Another key informant explained that her organization supported the joint Society of Obstetricians and Gynecologists of Canada/Canada Association of Radiologists (SOGC/CAR) statement that ultrasound should not be used solely for non-medical reasons to determine sex. However, this key informant also stated that her organization supported a woman's right to choose termination of pregnancy as an option.

We also support an individual's right to self-determination, so that's not really our place to pass judgment.

– Key Informant #1

The last participant stated that she disagreed with the regulation or ban of sex-selective abortion. She felt that women had the legal right to an abortion, and sex preference was an acceptable reason for termination. Additionally, this key informant stated that sex-selective abortions occurred more frequently in countries where the practice was illegal in comparison to areas where it was legal, suggesting that these laws are counter-productive. Instead, this participant felt that efforts should be focused on empowerment of women.

The issues should all be related to the cultural acceptance of women in a family. And those are the areas that need to be worked on, not sex-selective abortions.

– Key Informant #3

### **Improvements in Abortion Provision**

#### *Punjabi women face challenges with language and newcomer status*

All of the key informants suggested that language and newcomer status might be barriers for Punjabi women. First, communication with the clinic staff was stated as an obstacle for Punjabi women with English language difficulties. As one participant stated, making that first phone call, explaining the issues and asking questions may make accessing care difficult for those with language barriers. Secondly, new Canadians may have trouble with systems navigation in an unfamiliar country. One key informant explained that newcomer Punjabi women might not know how to search for resources or even where to begin when

facing an unplanned pregnancy. Another participant suggested that newcomer communities might not even know that there are programs available for them.

So, often it can be challenging because some communities don't know that programs like ours exist, and feel as though they don't have options and they're isn't anyone that they can talk to about the circumstance that they're facing.

– Key Informant #1

Finally, access to information can be a significant challenge for Punjabi women who have language barriers. One key informant suggested that many newcomer women are unaware of the resources available to them because the information is not in Punjabi. As well, two participants mentioned issues with the process of having family members call and relay information to Punjabi women. For example, there is no way of knowing whether the information being relayed is accurate. In addition, dependence on family members may be undesirable if the family relations are not good.

#### *Language and informational resources are recommended*

In order to help Punjabi women overcome some of the challenges with language barriers, two participants suggested that clinics integrate the Punjabi language into their services. For example, one participant suggested the use of an interpreting service, while another stated that it would be beneficial for clinics to have Punjabi staff. As well, one key informant stated that all materials at her facility were translated into Punjabi, thus making information access easier for newcomer women.

Two of the participants suggested more availability of informational services for Punjabi women. One key informant gave the example of the program targeted towards newcomer communities at her place of work. This resource offers women's groups in the native language of the clients, where they are provided with health care information. Additionally, another key informant suggested that more knowledge be provided to women by their family doctors. This participant stated that Punjabi women might choose to go to Indian physicians due to the difficulty of communicating with a non-Indian doctor. However, they may not feel comfortable discussing contraceptive options or abortion care with physicians of a similar ethnic background, due to fear of judgment. This key informant suggested that all doctors be more open to providing patients with contraceptive options and abortion information.

## **CHAPTER FIVE: DISCUSSION & CONCLUSION**

### **Positionality & Reflexivity**

Throughout the data collection process, it was important to consider my positionality as a researcher and how this could affect progression of the study. Being a Punjabi-Canadian woman myself, I am knowledgeable of the cultural background of this community. As a result, I had unique insight into the perspectives of Punjabi women. I found that this positionality allowed some women to be more comfortable in discussing certain aspects of Punjabi culture, as they had assumed I was already aware of these aspects. On the other hand, as highlighted in this study, there is a possibility that Punjabi women prefer interacting with non-Punjabi health care professionals. Similarly, I realize that there might also be a possibility that Punjabi women may not feel comfortable discussing their personal abortion experiences with another Punjabi individual. Thus, my ethnic background may have influenced women's decision to participate in this study.

As a qualitative interviewer, it is likely that my own subjective biases influenced my interactions with the participants. Before conducting interviews for my own thesis, I observed and led in-depth interviews with women for the Canada Abortion Study. This process helped me to critically evaluate and reflect on the values and biases I bring to this work and afforded me an opportunity to practice minimizing their impact on the interviewer-participant interaction for my own study. In addition, my experience as an interviewer for the Canada Abortion Study allowed me to gain insight into the responses of the participants and relate

this information to the findings of my own research project. Through this process, I was able to compare the abortion experiences of Canadian women in general to those of the Punjabi participants in my own study.

## **Study Findings & Significance**

The design of the in-depth interview component was guided by the design of the larger Canada Abortion Study. The in-depth interviews demonstrate that there exist few differences between the experiences of Punjabi and Punjabi-Canadian women specifically, and Canadian women in general. The abortion experiences for both groups of women are extremely similar, and there are no significant differences in the abortion care received by Punjabi women. The interviews with key informants also reiterate this finding, as one key informant did not find anything outstanding while provided services to this population. The key informants that did find some differences in the Punjabi population described traits that could be easily shared by women of other ethnic backgrounds. For example, it is possible that partner support, aversion to hormonal contraception, and timing of family may be important for non-Punjabi women as well.

Interestingly, there are similarities between the findings of the in-depth interviews and the key informant interviews. Both the Punjabi women and the key informants express that pregnancy timing is a key factor in the abortion decision. The precise timing of starting a family seems to be important to Punjabi women. In addition, the importance of family support seems to be a common finding between in-depth interview participants, as well as key informants. As mentioned



by key informants, family members are often involved in abortion decisions. In-depth interview participants also highlight the importance of family support in pregnancy. Moreover, both key informants and Punjabi women brought up the theme of fetal sex determination during a discussion on sex-selective abortion. This suggests that a desire to know pre-natal sex may be common amongst the Punjabi community, not specifically for sex selection purposes. Finally, one key informant suggests that Punjabi women may avoid interactions with health professionals of similar cultural backgrounds. Similarly, one in-depth interview participants described the lack of trust she has in her family physician due to similar ethnicity.

Another finding was the role of family doctors in the abortion care that women received. The in-depth interviews highlighted the effects of the patient-physician relationship on women's abortion experiences. For example, this relationship dictated where women went for their initial appointments, where they chose to have their follow-up appointments, and from which health professional women would have preferred to receive mifepristone. Some in-depth interview participants also mentioned the role of family doctors in pregnancy options counseling. These women felt that family doctors should either provide more counseling or provide resources for this service. Finally, one key informant also suggested that more contraception and abortion information be provided to women from their family doctors. This reveals that family physicians play an important role in the abortion process.

## **Implications for Sex-Selective Abortion**

The literature on abortion among Punjabi women focuses exclusively on sex-selective abortion. Media reports and political discourse often assume that women of Indian or Chinese descent undergo abortion solely for the purpose of sex selection, asserting son preference as a deep-seated cultural value. However, this research project shows that sex selection is not the sole reason behind abortion practices in this population. Son preference was not expressed by any of the Punjabi women in this study. Furthermore, a study conducted by Dickens et al. (2005) found that son/daughter preference was uncommon in Canadians; however, the concept of family balancing – that is, having children of both sexes in the family unit – was an important value among the majority of prospective parents. One key informant, who mentioned that sex preference was an important value among women of all ethnic backgrounds, reiterated this dynamic. Although sex-selective abortion may be a method of family balancing used by all ethnic populations, this dynamic has rarely been explored in published research. Thus, it is possible that the elevated birth ratios in immigrant populations in Canada may be motivated by family balancing desires rather than cultural factors or son preference.

A commonly suggested method of normalizing sex ratios is the criminalization of sex-selective abortion. However, proposals of this type are problematic on a number of different grounds. As stated by a key informant in this study, there is no evidence that bans on sex-selective abortion actually address skewed birth ratios. Vogel (2012) notes that India's male-to-female ratio

has steadily worsened since the country introduced its ban on sex-selective abortion in 2003. Second, there are significant challenges with enforcement as it is extremely difficult to “prove” that an abortion procedure was performed for sex selection purposes. Laws that penalize clinicians who provide sex-selective abortions could potentially make every second trimester abortion provider a criminal (Ganatra, 2008). Third, banning sex-selection abortion may have a negative impact on abortion care in general. For example, the Indian government attempted to make the availability of medication abortion more difficult as a way to restrict sex-selective abortion (Iyengar, Iyengar & Gupta, 2009). Moreover, women may seek more dangerous methods of pregnancy termination (for sex selection or other reasons). Finally, the restriction of abortion has ethical implications on women’s rights. As Ganatra (2008) explains, restriction on abortion practices further marginalizes vulnerable women and increases both cost and the potential for exploitation. One key informant reiterated this point by describing the experiences of South Asian women in the clinic across the border. It is likely that this clinic is providing false information for fetal sex determination in order to have women pay for abortion services.

Another issue is that the research surrounding sex-selective abortion in Western countries has recently become a topic of politicized discourse. It is not uncommon for anti-choice organizations to use the research as a justification for restricting abortion in Canada. Calabrasi (2008), an anti-choice legal strategist, explains that placing bans on sex-selective abortions is a strategy employed by anti-choice movements in order to restrict the practice of abortion in general. In

addition, Ganatra (2008) states that anti-choice media often carry reports and images of female fetuses found abandoned in wells, lakes, and drains. However, many of these are stillbirths at over six months gestation, which is well beyond the gestational limit for abortion in most countries. One in-depth interview participant described seeing similar images depicted by anti-choice protestors.

Instead of regulation or bans, one key informant recommended that efforts be focused on the empowerment of women in society. Similarly, Woolhouse (2012) suggests that the long-term solution lies in raising awareness of gender inequality as a determinant of health at a global level, as well as education and empowerment of women worldwide. Ganatra (2008) provides the example of South Korea, where the sex ratios have gradually begun to return to “normal” because of greater workforce participation of women, more education of women, and implementation of laws associated with women’s rights rather than restrictions on abortion practices.

### **Challenges & Limitations**

One major challenge with this study was the difficulty in recruiting participants. Due to the stigma and the negative connotations associated with abortion in Punjabi culture, it is likely that women were hesitant to share their experiences. It is also likely that key informants simply do not have the relevant experience in providing abortion services to Punjabi women, since it is a minority population in Canada. Since there were so few participants, this study was not able to reach thematic saturation. Another limitation is the lack of Punjabi women from Pakistan in this study. The background literature suggests that Pakistani-

Punjabi women have differing abortion experiences from Indian-Punjabi women, and this dynamic could not be reflected in this study. Due to the lack of these participants, the viewpoints and perspectives of a range of Punjabi women could not be expressed in this research project. As a result of these limitations, the transferability of the findings must be considered. Due to the small sample of participants, these findings are not meant to be representative or generalizable of the Punjabi population in Canada.

In order to recruit more participants and reach thematic saturation, there could have been improvements in recruitment methods. The participants in this study responded mainly to online advertisements, distribution of information by community organizations, and personal networking. In order to reach more participants, there could have been more outreach towards media channels targeted specifically to the Punjabi population. As well, the recruitment for British Columbia participants did not begin until well into the data collection process. It is possible that if recruitment for British Columbia had begun sooner, the study could have had more in-depth interview and key informant participants. Finally, alterations could have been made to the study design. Instead of focusing on Punjabi women specifically, the study population could have focused on the South Asian community more broadly. This would have facilitated recruitment of key informants who had experiences serving the South Asian population outside of Punjabi women, as well as allowed for a broader range of eligible in-depth interview participants.

## **Statement of Contribution**

I completed this research project on partial fulfillment of the requirements for the Master of Science in Interdisciplinary Health Sciences program at the University of Ottawa. As the principal investigator, I was responsible for all components of the project, including conceptualization of the study design, development and translation of interview guides, recruitment of participants, data collection, interview transcription and data analysis.

As the supervisor for this project, Dr. Angel Foster reviewed all components of the study. Dr. Foster worked closely with me to design the study and develop the interview guides and recruitment materials. As well, Dr. Foster guided me through various components of the research process, including development of the thesis proposal and obtaining REB approval. Finally, Dr. Foster aided in the recruitment process by distributing information regarding the study to potential participants.

## **Conclusion & Future Directions**

The finding of my thesis shed light on the abortion experiences of Punjabi women in Canada. Although they represent a large portion of the Indian immigrant and Indian-Canadian population, there is little research done on the reproductive health, let alone the abortion experiences, of Punjabi women. By including key informant interviews, this study explores different perspectives on providing care for this community. The findings from this study can be considered as a starting point for addressing the research questions outlined in this thesis.

In addition to this thesis, I conducted a literature review on the topic of sex-selective abortion in Canada (included in **Appendix C**). A finding from this

literature review was the lack of qualitative studies on sex selection practices.

Much of the available research is focused on sex ratios in immigrant populations, and often assumptive in nature. Thus, it would be beneficial to conduct qualitative research that reflects the motivations and reasons behind sex selection, in order to gain a better understanding of this phenomenon. Furthermore, as there exists minimal research on the Punjabi population in Canada, it would be beneficial to have more studies on this specific population rather than focusing on immigrants or Asian individuals as a whole.

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## APPENDIX A: Map of Punjab



## **APPENDIX B: REB Approval – In-Depth Interviews**

File Number: H08-12-08

Date (mm/dd/yyyy): 03/30/2016



**Université d'Ottawa**  
Bureau d'éthique et d'intégrité de la recherche

**University of Ottawa**  
Office of Research Ethics and Integrity

### **Ethics Approval Notice** **Health Sciences and Science REB**

#### **Principal Investigator / Supervisor / Co-investigator(s) / Student(s)**

| <u>First Name</u> | <u>Last Name</u> | <u>Affiliation</u>          | <u>Role</u>            |
|-------------------|------------------|-----------------------------|------------------------|
| Angel             | Foster           | Health Sciences / Others    | Principal Investigator |
| Danielle          | Bessett          | Social Sciences / Sociology | Co-investigator        |
| Jennifer          | Cano             | Health Sciences / Others    | Student Researcher     |
| Prabjyot Kaur     | Chahil           | Health Sciences / Others    | Student Researcher     |
| Arielle           | Kaneza           | Health Sciences / Others    | Student Researcher     |
| Kathryn           | LaRoche          | Health Sciences / Others    | Student Researcher     |
| Michelle Deanne   | Miller           | Health Sciences / Others    | Student Researcher     |
| Kristina          | Vogel            | Health Sciences / Others    | Student Researcher     |
| Mona              | El-Mowafi        | Health Sciences / Others    | Research Assistant     |
| Miriam            | Grenon           | Health Sciences / Others    | Research Assistant     |
| Andréanne         | Chaumont         | Health Sciences / Others    | Project Coordinator    |
| Julie             | El-Haddad        | Health Sciences / Others    | Project Coordinator    |

**File Number:** H08-12-08

**Type of Project:** Professor

**Title:** Canadian abortion study

| <b>Renewal Date (mm/dd/yyyy)</b> | <b>Expiry Date (mm/dd/yyyy)</b> | <b>Approval Type</b> |
|----------------------------------|---------------------------------|----------------------|
| 11/05/2015                       | 11/04/2016                      | Ia                   |

(Ia: Approval, Ib: Approval for initial stage only)

## **APPENDIX B: REB Approval – Key Informant Interviews**

File Number: 03-15-29

Date (mm/dd/yyyy): 03/30/2016



**Université d'Ottawa**  
Bureau d'éthique et d'intégrité de la recherche

**University of Ottawa**  
Office of Research Ethics and Integrity

### **Ethics Approval Notice** **Social Sciences and Humanities REB**

#### **Principal Investigator / Supervisor / Co-investigator(s) / Student(s)**

| <u>First Name</u> | <u>Last Name</u> | <u>Affiliation</u>       | <u>Role</u>        |
|-------------------|------------------|--------------------------|--------------------|
| Angel             | Foster           | Health Sciences / Others | Supervisor         |
| Prabjyot Kaur     | Chahil           | Health Sciences / Others | Student Researcher |

**File Number:** 03-15-29

**Type of Project:** Master's Thesis

**Title:** Exploring the abortion experiences of Punjabi women in Ontario

| <b>Renewal Date (mm/dd/yyyy)</b>                           | <b>Expiry Date (mm/dd/yyyy)</b> | <b>Approval Type</b> |
|------------------------------------------------------------|---------------------------------|----------------------|
| 04/09/2016                                                 | 04/08/2017                      | Ia                   |
| <b>(Ia: Approval, Ib: Approval for initial stage only)</b> |                                 |                      |

**Special Conditions / Comments:**  
N/A

## **APPENDIX C: Literature Review**

### **Sex-Selective Abortion in the Canadian Context: A Review of the Literature**

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Faculty of Health Sciences

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Submitted to the *Interdisciplinary Journal of Health Sciences*

**Abstract**

Sex-selective abortion is a phenomenon that has been widely associated with India and China. However, a review of the current literature suggests that this practice may be occurring among Asian immigrant populations in Canada. Studies have shown that the male-to-female birth ratios are elevated among East Asian and South Asian immigrants. There are trends associated with elevated sex ratios and higher birth parity, as well as elevated sex ratios and induced abortion. Further, studies on the attitudes of health care professionals have revealed that many believe sex-selective abortion is present in the Canadian context. Much of the literature also contains editorials and opinion pieces debating the ethics and regulation of sex selection in Canada. Missing from the literature, however, is qualitative research on the motivations behind sex selection. Future research on sex-selective abortion should take this into consideration.

**Key Words**

Sex Selection, Abortion, Canada, Sex Ratios, Birth Ratios



## **Introduction**

Sex selection is a phenomenon that has existed worldwide for decades. Emerging reproductive technologies have prompted a distinction between medical and social sex selection. Medical sex selection refers to selection of fetal sex in order to avoid X-linked diseases, such as hemophilia (Puri & Nachtigall, 2010). In contrast, social sex selection refers to fetal sex selection for the purposes of family planning and balancing (Puri & Nachtigall, 2010). Globally, there currently exist three methods of sex selection: sex-selective in vitro fertilization, sperm sorting, and sex-selective abortion. Sex-selective in vitro fertilization uses a profiling technique, called pre-implantation genetic diagnosis, in order to disclose the sex of the embryo; thus allowing for selective implantation of embryos based on preferred fetal sex (Dickens, Serour, Cook, & Qiu, 2005). Sperm sorting is a technique used to separate X-bearing and Y-bearing sperm in order to condition the sex of an embryo for in vitro procedures (Dickens et al., 2005). Finally, sex-selective abortion is the termination of pregnancy based on fetal sex, which is determined through methods such as ultrasound, amniocentesis, and fetoscopy (Dickens et al., 2005). Fetal sex determination followed by subsequent abortion, typically between eight to twenty weeks gestation, remains the most common method of sex selection worldwide (World Health Organization, 2016).

The World Health Organization (2016) has identified two countries, India and China, where the practice of sex-selective abortion is sufficiently prevalent that national sex ratios have become distorted. There are many cultural, religious, and socio-economical dynamics that motivate the practice of sex selection in India and China. Research suggests that the concept of son preference is the underlying factor behind such

motivations. In both Indian and Chinese culture, daughters are perceived as having lower value, as they cannot inherit family land (Hesketh, Li & Xing, 2011). Daughters are also unable to provide support in old age, as there exists social disapproval of parents residing with married daughters (Kulkarni, 2012). Furthermore, it is common for sons to have better economical opportunities than daughters. For example, many farm-dependent economies in India require male workers, so parents may depend on their sons to financially provide for the family (Ganatra, 2008). In India, the dowry system is also a major contributor to the economic disadvantage of daughters (Ganatra, 2008). In addition, the importance of having sons may be influenced by their role in religious ceremonies. The death rite tradition in Hinduism is required to be performed by men only (Ganatra, 2008). Confucian traditions also task men with the responsibility for ancestor worship (Ganatra, 2008). Along with cultural and religious factors, research shows that China's family planning policies were likely associated with the practice of sex selective abortion (Attane, 2009).

Indeed, while contemplating the phenomenon of sex-selective abortion, one might automatically link this practice to countries such as India and China. It is often assumed that such a phenomenon is absent from the Global North, as the same cultural and economic factors that motivate sex selection in India and China may not be relevant in Western societies. Moreover, these assumptions may derive from the fact that there are no laws governing sex-selective abortion in Western countries such as Canada, contrary to laws present in India and China. Abortion services in Canada are financially covered and widely available, without restriction on fetal gestational age (Almond, Edlund, & Milligan, 2013). However, a review of the literature reveals that sex-selective abortion

research does, in fact, exist in the Canadian context. In this literature review, I explore what is currently known about the practice of sex-selective abortion in Canada.

## **Methods**

In order to identify relevant peer-reviewed articles for this topic, I began by conducting searches in four research databases: PubMed, Medline, Scopus, and JStor. For each database, I used five different search terms, which yielded a broad range of results. The search terms used were as follows: “sex selective abortion”, “sex selective abortion Canada”, “sex abortion Canada”, “sex ratio Canada”, and “sex determination Canada”. I also scanned the citations for each article obtained from the research databases, in order to ensure that I did not miss any relevant studies. Finally, I obtained grey literature by conducting a Google search using the five search terms outlined above.

As there is very little research available on sex-selective abortion in Canada, I used broad selection criteria in order to obtain my articles. After initially identifying key terms such as “sex-selection”, “sex-selective abortion”, and “sex ratios” in the title of each article, I read through the abstract in order to gain a better understanding of the study. I then selected research that was published in Canada, and was focused on sex selection, possibly through the avenue of abortion. Initially I had selected 21 articles to be used in this literature review.

After careful examination of each article, I applied exclusion criteria in order to ensure that I had peer-reviewed research studies. I excluded four news articles, as these reiterated information that was already available from original research articles. I also excluded four journal articles that focused on sex-selective abortion solely from the ethics

perspective, without referring to the practice in the Canadian context. Finally, I excluded four opinion pieces and editorials, as these articles subjectively debated regulation of the practice in Canada. I did, however, reference some of these articles in the discussion section. I did not exclude any articles based on year, as I found all of the studies to contain information that is relevant to current sex-selective abortion practices. I included a total of 11 peer-reviewed articles and seven grey literature documents in my review.

## **Results**

### Introduction to Sex Ratios

Most of the research on sex-selective abortion is focused on male-to-female birth ratios, or sex ratios. These are ratios used to compare the number of male births to every 100 female births in a given population. The “normal” birth ratio is cited as 105 males to 100 females, or 1.05 (Hesketh & Xing, 2006). Significant deviation from this number leads researchers to believe that there may be a possibility of sex selection within a population. When this number is significantly elevated, it is assumed to be a result of sex selection in favour of males.

### Sex Ratios in Canada

Seven out of the 11 peer-reviewed studies were focused on male-to-female birth ratios in Asian immigrant populations. The first reference to sex ratios occurred throughout the years 1970 to 1990, a key time period for immigration in Canada. Interestingly, one study reveals that the national sex ratio in Canada has actually decreased from 1970 to 1990, despite the increasing proportion of Asian immigrants

within that time period (Allan, Brant, Seidel, & Jarrell, 1997). Another study looked more closely at immigrant groups during that same time period, and found that the sex ratio was lower in African-Canadian populations and slightly higher in Asian populations (Dodds, 1997).

### Sex Ratio & Birth Parity

Since then, researchers have noticed a trend involving birth parity within Asian immigrants in Canada. Almond, Edlund, & Milligan (2013) found that sex ratios were significantly elevated for higher-order births if previous children were all female. Among Asian immigrants having a second child, the sex ratio was reported as 1.16 (Almond, Edlund, & Milligan, 2013). A separate study conducted in Quebec had similar results, where parents with an Asian birth region had higher sex ratios for the second birth in comparison to the first birth (Auger, Daniel, & Moore, 2008). Almond, Edlund, & Milligan (2013) also examined the mother's age of immigration in relation to male-to-female birth ratios. The researchers found that the birth ratio was higher for third children (1.50) in immigrants who arrived after age 18, in comparison to immigrants who arrived during childhood (1.23).

### Birth Ratios in South Asian Populations

In most of the studies, there appeared to be significant elevation of birth ratios among Indian immigrant populations. Almond, Edlund, & Milligan (2013) found the sex ratio to be 1.19 for second-order births and 1.90 for third order births in Indian-born mothers. Similarly, Ray, Henry, & Urquia (2012) noticed significantly elevated birth

ratios among Indian-born mothers for second (1.36) and third (1.25) children. Another study revealed that women who had immigrated from India were almost 3 times more likely to give birth to a male after previously given birth to two females (Urquia, Moineddin, Jha, Ocampo, McKenzie, Glazier, Henry, & Ray, 2016). In a separate study, Urquia, Ray, Wanigaratne, Moineddin, & O'Campo (2016) compared male-to-female birth ratios by maternal and paternal country of birth, and found that the highest ratio in Canada was among two Indian-born parents. Finally, parents in Quebec who spoke Indo-Pakistani languages at home had a higher birth ratio (1.21) for first-order births in comparison to the overall Canadian male-to-female ratio (1.06) (Auger, Daniel, & Moore, 2008).

#### Birth Ratios in East Asian Populations

Among these studies, the second most prevalent population was Chinese immigrant mothers. Ray, Henry, & Urquia (2012) found that the first-order birth ratio was slightly higher in Chinese immigrant mothers (1.09) in comparison to other immigrant groups in Canada. In addition, women who immigrated from China and who had a third child were 1.5 times more likely to have two daughters than two sons (Urquia et al., 2016). Ray, Henry, & Urquia (2012) also found similar trends while studying South Korean immigrant populations. Their study revealed that birth ratios remained unchanged for Canadian-born mothers, while women born in South Korea had a significantly higher sex ratio (1.20) for second-order births. In contrast to other East Asian populations, mothers from the Philippines had sex ratios close to the normal ratio

for all births, including third children preceded by two girls (Almond, Edlund, & Milligan, 2013).

#### Mixed Nativity Birth Ratios

Researchers also wanted to assess whether there was a deviation in sex ratios for Asian immigrant populations when one of the parents were Canadian-born. They found that sex ratios were elevated for higher order births only. For example, Almond, Edlund, & Milligan (2013) found the sex ratio to be 1.32 for third order births for Asian families in which one parent was Canadian-born. Similarly, among couples involving a Canadian-born mother and an Indian-born father, the male-to-female birth ratio was 1.46 for fourth-order births (Urquia et al., 2016).

#### Sex Ratios & Religion

Almond, Edlund & Milligan (2013) also analyzed birth ratios in the context of religion. They found that birth ratios were relatively normal for Asian immigrants who identified as Christian or Muslim. The highest sex ratios were found in Asian immigrants who identified as Sikh, a religious community originating from northern Indian state of Punjab (Almond, Edlund, & Milligan, 2013). For this group, there were more than two boys per girl for third-order births, if the previous two children were female (Almond, Edlund, & Milligan, 2013).

#### Sex Ratios & Induced Abortion

Urquia et al. (2016) found the most pronounced effect on sex ratios in third-order births among Indian-born mothers following induced abortion. The researchers revealed that the ratio was significantly higher among women who had an induced abortion (3.26) in comparison to those who did not have an induced abortion (1.68) (Urquia et al., 2016). Interestingly, an induced abortion among Indian-born women with two sons was extremely uncommon (Urquia et al, 2016). These findings suggest the use of sex-selective abortion due to son preference in the Indian immigrant population.

### Son Preference in Canadians

One out of 11 peer-reviewed articles focused on sex preference in countries around the world. Balen (2006) found that there was a 10% higher preference for sons among the Canadian population in comparison to other countries. Out of the seven grey literature documents, one was an unpublished study exploring the motivations behind son preference in Asian immigrant populations. A survey conducted by Clelland (2013) revealed that 16% of Asian-born participants expressed preference for a son. Out of those who expressed son preference, 67% of participants cited economic motivations as a contributing factor (Clelland, 2013). Other motivations included personal preference, cultural/societal expectations and family pressure (Clelland, 2013). These findings suggest that the motivations behind son preference in India and China may exist in the Canadian context.

### Attitudes Among Health Professionals



Three of the 11 peer-reviewed articles focused on the attitudes of physicians and geneticists on the practice of sex selection. Bouchard, Renaud, Kremp, & Dallaire (1995) surveyed physicians in Canada and found that most considered sex-selective abortion to be unacceptable. In contrast to these findings, Wertz & Fletcher (1993) revealed that the general consensus among Canadian physicians was that patients should have the freedom to do whatever they wished with the information provided by medical tests. Another study among Canadian geneticists showed that 30% of participants were willing to perform prenatal diagnosis for sex selection (Wertz, Fletcher, & Mulvihill, 1990). In addition, most geneticists believed that the practice sex selection was occurring in Canada (Wertz & Fletcher, 1993). It is important to note that all of the studies detailing health professional's attitudes were done over 20 years ago, and perspectives may have changed as new information on sex selective technology became available.

#### Governing Bodies on Sex-Selective Abortion

The Government of Canada (2004) in its Assisted Human Reproduction Act states that any procedure that increases the chance that an in vitro embryo will be of a particular sex is prohibited. According to this law, sex selection of embryos using sperm sorting and in vitro fertilization is prohibited. Since there is no prohibition on sex selection once the embryo becomes a fetus, abortion for the purpose of sex selection is legal. Yet in recent years a number of normative bodies have issued statements regarding sex selective abortion. The Royal Commission (1994), the Society of Gynecologists and Obstetricians (2007) and the College of Physicians and Surgeons in Ontario (2010) have all stated they do not support the practice of using fetal ultrasound and abortion for sex selection

purposes. However, the Society of Gynecologists and Obstetricians (2012) and the College of Physicians and Surgeons in British Columbia (2012) have also issued statements describing patients' rights to full disclosure from diagnostic procedures, including fetal sex determination.

## **Discussion**

The research on sex ratios allows us to make two inferences: (1) the male-to-female birth ratios are elevated for some Asian immigrant populations in Canada, and (2) these elevations are assumed to be a result of sex selection. However, with the exception of the Urquia et al. study that looked at induced abortion in relation to sex ratio, these elevated sex ratios cannot be linked with the practice of sex-selective abortion specifically. These ratios may be elevated due to other sex selection methods, such as in vitro fertilization. Furthermore, a wide range of factors other than sex selection can also affect sex ratios. Dodds (1997) cites some of these factors: race, birth order, parental age, parent hormone levels, timing of conception, ovulation induction, environmental toxins, and socioeconomic status.

As well, it is important to take a closer look at the numbers obtained for the sex ratios. These ratios may not present a significant difference when they are taken into context. For example, in the study conducted by Almond, Edlund, & Milligan (2013), the sex ratio for Asian immigrants having a second child was reported as 1.16; however, when this number was translated into percentages, these women had only a 2.1 percent higher chance of giving birth to a boy. Moreover, some of the sample sizes for the immigrant groups may not have been large enough to rule out other factors contributing

to male-biased sex ratios. For example, in the study conducted by Ray, Henry, & Urquia (2012), South Korean immigrants had a significant elevation in second-order birth ratios (1.20) in comparison to Canadian-born women. However, the sample size for births in South Korean immigrants ( $n=3,663$ ) was much smaller than the sample size for births in Canadian-born women ( $n=486,599$ ). Ray, Henry, & Urquia (2012) specified that their study consisted of 64% Canadian-born women, 4% Indian-born women, 3% Chinese-born women and 2% Pakistani-born women; thus, the sample sizes for all Asian immigrant groups were much smaller in comparison to the Canadian-born base group.

Another issue with the current literature is the focus on immigrant populations and populations of Asian descent. Media reports and political discourse often assume that women of Indian or Chinese descent undergo abortion solely for the purpose of sex selection. However, these accounts fail to recognize that many of the economic dynamics shaping son preference in countries like China and India are less present. In the Canadian context, broadly Asian genetic or cultural factors cannot explain elevated sex ratios (Almond, Edlund, & Milligan, 2013). For example, in the study conducted by Almond, Edlund, & Milligan (2013), women born in the Philippines had normal sex ratios for all parities, including third children preceded by two girls. Moreover, a survey by Dickens et al (2005) found that the overwhelming majority of populations in Western countries – including immigrant groups – do not prefer children of one sex or the other; however, family balancing of both sexes was an important value. Rarely do studies in Asian immigrants attribute sex ratios to family balancing; rather, the focus is on son preference as a deep-seated value.

In many of the peer-reviewed editorial reports, a commonly suggested method of normalizing sex ratios was the criminalization of sex-selective abortion. However, there is no evidence that bans on sex-selective abortion actually correct skewed birth ratios. Vogel (2012) notes that India's male-to-female birth ratio has worsened since the country introduced its ban on sex-selective abortion in 2003. Similarly, according to Li (2007), the number of "missing girls" in China has increased since the outlaw of sex-selective abortion in 1994. Restriction of sex-selective abortion also has negative implications on women's health and safety. In the face of these bans, and less accessible abortion care, women may seek more dangerous methods of pregnancy termination for sex selection.

Another option for regulating sex-selective abortion in Canada is restriction of fetal sex determination until after 20 weeks gestation. However, this is also problematic for a number of reasons. First, the restriction of fetal sex determination has implications on patient's rights. As described by SOCG (2012), women seeking abortion have a right to full disclosure, including fetal sex determination through the use of ultrasound. Second, restriction of fetal determination takes the decision-making power away from women. As Ganatra (2008) explains, this may further marginalize vulnerable women and increases the potential for exploitation. For example, having a female baby may put a woman at risk of discrimination, isolation from her community, and abuse (Woolhouse, 2012). Finally, these types of restrictions would simply not be effective, as there are methods of fetal sex determination. For example, Puri & Nachtigall (2010) describe the use of kits, marketed directly to consumers, which are able to determine fetal sex through a blood sample.

It is also important to recognize some of the motivations behind regulation of sex-selective abortion in Canada. It is not uncommon for anti-choice organizations to use the research as a justification for restricting abortion overall. Calabrasi (2008), an anti-choice legal strategist, explains that placing bans on sex-selective abortions is a strategy employed by anti-choice movements in order to restrict the practice of abortion in general. Another method employed in anti-choice discourse is the use of language such as “female feticide”, which personifies the fetus and promotes ideas of killing and murder (Ganatra, 2008). Indeed, this type of language is included in reports on sex-selective abortion produced by anti-choice organizations in Canada.

Instead, Woolhouse (2012) suggests that the long-term solution lies in raising awareness of gender inequality as a determinant of health at a global level, as well as education and empowerment of women worldwide. Ganatra (2008) provides the example of South Korea, where the sex ratios have gradually begun to return to “normal” because of greater workforce participation of women, more education of women, and implementation of laws associated with women’s rights rather than restrictions on abortion practices.

## **Conclusion**

The current literature reveals that there are elevated male-to-female birth ratios among Asian immigrant populations in Canada. These may be attributed to sex selection, including the use of fetal sex determination followed by abortion. Studies cite son preference as a contributing factor to these deviated sex ratios; however, family balancing may be an underreported phenomenon among Asian immigrants. As elevated sex ratios

have already been established among these populations, it may be beneficial to conduct more studies on the motivations behind sex selection among Canadians. As well, it may be valuable to conduct research on the health provider perspective, as the review of current literature reveals that these studies are outdated. There is a lack of qualitative data among the literature; thus, this approach should be considered for future research.

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