CENTER FOR REPRODUCTIVE RIGHTS

August 3, 2006

Dear Committee Members:

The Committee on the Elimination of Discrimination of Discrimination against Women (CEDAW Committee)

Re: Supplementary Information on China
Scheduled for review during the CEDAW's 36th Session

This letter is intended to supplement the periodic report submitted by China, which is scheduled to be reviewed by this Committee during its 36th Session. The Center for Reproductive Rights (The Center), an independent non-governmental organization, hopes to further the work of the Committee by providing independent information concerning the rights protected in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). This letter highlights several areas of concern related to the status of women's reproductive health and rights in China.

Reproductive rights are fundamental to women's health and social equality and an explicit part of the Committee's mandate under CEDAW. The commitment of States Parties to uphold and ensure these rights should receive serious attention. Specifically, the Convention commits States Parties to: "ensure…access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning" [Article 10(h)]; "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning" [Article 12(1)]; "take all appropriate measures to eliminate discrimination against women in rural areas in order to assure…access to health-care facilities, including information, counseling and services in family planning…" [Article 14(2)(b)]; and, to "take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women: …[t]he same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights" [Article 16(1)(e)].[1]

The Committee's General Recommendation 24 on Women and Health affirms that "access to health care, including reproductive health, is a basic right under [CEDAW]"[2] and is essential to women's health and well-being.[3] Furthermore, it obligates States Parties to take the following measures: "report on how public and private health-care providers meet their duties to respect women's rights to have access to health care,"[4] "[e]nsure the removal of all barriers to women's access to health services, education and information, including in the area of sexual and reproductive health, and, in particular, allocate resources for programmes directed at adolescents for the prevention and treatment of sexually transmitted diseases, including HIV/AIDS,"[5] "...[r]educe maternal mortality rates through safe motherhood services and prenatal assistance,"[6]and finally, to [r]equire all health services to be consistent with the rights of women, including the rights

to autonomy, privacy, confidentiality, informed consent and choice."[7] In its General Recommendation 19 on Violence against women, the Committee specifically obligates States Parties to "ensure that measures are taken to prevent coercion in regard to fertility and reproduction."[8] Also, according to General Recommendation 21 on Equality in marriage and family relations, States parties "should resolutely discourage any notions of inequality of women and men which are affirmed by laws, or by …custom."[9]

The government of China's combined fifth and sixth periodic report highlights several areas of concern with regard to women's reproductive health which have implications for their reproductive and sexual rights. For example, the report discusses efforts that have been made to reduce maternal mortality rates; campaigns to detect and treat diseases that tend to be common among women; the promotion of efforts aimed at preventing sexually transmitted diseases (STDs) and AIDS; and, actions aimed at promoting gender equality.[10] In addition, the report discusses legislative reforms aimed at addressing reproductive rights issues, such as the amendment of the Premarital Health Care Guidelines and the promulgation of the Law on Population and Family Planning and the Regulations on the Administration of Family Planning Technical Services.[11]

Nonetheless, despite notable progress, there are significant shortcomings in the government's efforts to comply with the Convention, as evidenced by the reality of women's lives in China. For example, the promulgation of the "Population and Family Planning Law," which gives the force of law to the "one-child policy" has the potential to, and has in fact been shown to have detrimental effects on the reproductive health and autonomy of women. In addition, despite greater access to contraception, there is a disproportionate number of females who undergo sterilization; legislation substantially limits access to infertility treatment for both single and married women; despite a national decrease in maternal mortality, rates continue to be high, particularly among rural women; and there is a significant lack of data on abortions performed in China. In addition, despite the fact that sexual activity among young people is on the rise, sexual education aimed at this population is absent; rates of HIV/AIDS and sexually transmitted infections (STIs) are a serious problem; and, finally, migrant populations within China face many problems associated with reproductive health, as a result of their particular conditions.

We would like to take this opportunity to bring to the Committee's attention the following issues of concern, which directly affect the reproductive health and lives of women in China:

I. Right to Health Care, Including Reproductive Health Care and Family Planning

A. Use of Penalties to Enforce Family Planning

The Population and Family Planning Law of China, which went into effect in September 2002, "advocates" that couples limit their family size to one child.[12] Under certain conditions ("where the requirements specified by laws and regulations are met") couples can request permission to have a second child.[13] Absent government permission, however, a second pregnancy "must be terminated under the directives of family planning technical service personnel," and a couple's refusal to undergo an abortion can result in a fine.[14]

In order to enforce the above law, the government rewards couples who comply and utilizes disincentives to penalize those who do not. For example, individuals who do not comply with the provision of the Population and Family Planning Law "encouraging late marriage and childbearing and advocating one child per couple" must pay a "social maintenance fee,"[15] which can amount to "several times the amount of an individual's annual income."[16] In instances in which a family is unable to pay this fee within the specified time, additional fees and charges are levied.[17] A failure to pay the fee can result in administrative sanctions or disciplinary actions from a work unit or organization.[18] In the case of civil servants and state functionaries who fail to comply, even harsher punishments are inflicted.[19] Additional penalties include having to assume financial responsibility for maternal health care costs, the denial of maternity insurance benefits for leave and subsidies and, in the case of rural citizens, the denial of future increases in land allocation.[20] Finally, further penalties include loss of housing and school benefits.[21] Also noteworthy is the fact that social compensation fees are also levied upon couples who are not married, women below the legal age for marriage, and parties of an extramarital affair who have a child.[22]

This Committee, in its Concluding Observations to China, has "urged" the government "to promote information, education and counselling, in order to underscore the principle of reproductive choice, and to increase male responsibility in this regard."[23] Further, it has encouraged the government to "make clear that coercive and violent measures are prohibited and enforce such prohibition through fair legal procedures that sanction officials acting in excess of their authority."[24] Finally, this Committee has "urged" the government "to introduce gender-sensitivity training for family planning officials."[25] It is hoped that the government of China will indeed ensure that men and women are able to exercise decision-making in the choices they make with regards to their reproductive lives. Coercion and violence in family planning have been strongly denounced by the international community and the continuing use of these techniques is inconsistent with the growing recognition of standards of informed and free consent, privacy, autonomy and dignity as important aspects of reproductive health care, notwithstanding national population imperatives. Coercive and violent measures to control people's reproductive lives must be outlawed on the principle that illegitimate means cannot be used to enforce public policy. National laws and policies must be enforced through positive means and with respect for basic constitutional and human rights. The state must refrain from adopting coercion as an official policy, especially in the context of family planning where such measures tend to have a disproportionate impact on women. Any acts of coercion should be officially sanctioned. Further, in outlawing and sanctioning these measures, the government should hold an expansive view of what acts and policies constitute coercive behavior.

B. Harmful Effects on Women as a Result of the One-Child Policy

China's one-child policy has been said to have detrimental consequences: for example, human rights violations that have been attributed to the policy include enforcement measures that involve violence, such as forced abortions, compulsory sterilizations and the forced implantation of intrauterine devices after a woman has undergone an abortion or given birth; and, the practice of sex-selective abortion, female infanticide, and the abandonment or hiding of female infants and children.[26]

Forced Abortion and Forced Sterilization as a Consequence of the One-Child Policy

Regarding forced abortion and compulsory sterilization, both this Committee and others have expressed concern about and issued recommendations calling for the elimination of coercive practices, including forced abortions and forced sterilizations, both of which, according to various reports, continue to occur in China.

In General Comment 19, this Committee has expressed that "compulsory sterilization or abortion adversely affects women's physical and mental health…"and that these practices violate the basic right to "decide on the number and spacing of [their] children."[27] Based on this concern, this Committee recommends that: "States parties should ensure that measures are taken to prevent coercion in regard to fertility and reproduction…"[28]

Elsewhere, in General Comment 21, this Committee categorizes forced abortions or sterilizations as "coercive practices which have serious consequences for women," and stresses that while a spouse or partner might be involved in decisions to have children or not, such a decision, for a woman "must not nevertheless be limited by spouse, parent, partner or Government."[29]

Finally, in General Comment 24, this Committee defines "acceptable services" as those that are "delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives."[30] The Comment goes on to provide as examples of practices that "violate women's rights to informed consent and dignity," any forms of coercion, including non-consensual sterilization.[31] In conclusion, this Committee recommends that States parties should "require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice."[32]

In specific relation to China, this Committee, in its Concluding Observations, has expressed concern that "notwithstanding the Government's clear rejection of coercive measures, there are consistent reports of abuse and violence by local family planning officials."[33] An example of such abuse and violence is forced sterilizations and abortions.[34] In order to address this problem, the Committee recommends that the government "make clear that coercive and violent measures are prohibited and enforce such prohibition through fair legal procedures that sanction officials acting in excess of their authority."[35] One practical method through which to do this is "to introduce gender-sensitivity training for family planning officials."[36]

Elsewhere, the Committee on Economic, Social and Cultural Rights, as recently as 2005, expressed "deep concern" regarding reports of forced abortions and forced sterilizations.[37] In particular, the Committee expressed concern about these practices being inflicted upon ethnic minority groups, in the name of the one-child policy.[38] As a result, the Committee "urged" the government to "undertake effective measures to ensure that abortions are carried out voluntarily and under adequate medical and sanitary conditions and to ensure that the existing legislation governing the one-child policy does not violate the rights enshrined in article 10 [article 10 governs the family, including marriage, motherhood and children and young persons] of the Covenant."[39]

In addition to the serious human rights violations that are implicated when a woman is forced to undergo an abortion or a sterilization, the absence of a woman's informed consent to these procedures violates basic medical precepts, as laid out by the World

Health Organization. According to WHO, "the informed consent of the patient is a prerequisite for any medical intervention."[40]

The 2004 Country Report on Human Rights Practices in China issued by the United States State Department contains information that confirms other reports of violations including violence against women, for example in the form of "a coercive birth limitation policy that resulted in instances of forced abortion and forced sterilization."[41] These coercive policies range from various types of pressure that are exerted on couples to the alleged use of physical force.[42] For example, it has been reported that women who are pregnant but are not authorized to be pregnant are visited by birth planning workers.[43] These workers allegedly use threats, such as the threat of the social compensation fee, to pressure women to terminate their pregnancies.[44] The combination of the burden of these fees as well as harassment from officials leave women "little practical choice but to undergo abortion or sterilization."[45] While actual physical force is not necessarily utilized, these practices do indeed constitute behavior that can be characterized as coercive.

Thus, the Chinese government should be encouraged to expand the range of policies and practices that are considered coercive and that should therefore be outlawed. For example, in instances in which birth planning workers engage in such coercive practices, they must be strictly sanctioned for doing so. By not strictly prohibiting and punishing acts of coercion and force, the Chinese government becomes responsible for such acts. The government should ensure that practices are aligned with national laws such as the "Regulations on Administration of Technical Services for Family Planning," according to which "individual voluntariness" and "personal consent" of the recipient of contraceptive or birth control surgery must be garnered.[46] Similarly, the Law on Maternal and Infant Health Care requires that "termination of gestation or performance of ligation operations practiced in accordance with the provisions of this Law shall be subject to the consent and signing of the person per se."[47] In addition, under the State Compensation Law, citizens are allowed to bring suits against officials who exceed their authority in the implementation of the birth planning policy.[48] Complaints of coercion, violence and abuse of power by family planning officials must be taken seriously by the government through the establishment of complaint mechanisms, performance of investigations, and the availability of legal remedies. The government should thus ensure that citizens are aware of this option and are provided with the necessary resources to bring such a suit when their rights have been violated.

Gender Imbalance and Sex-Selective Abortion as a Consequence of the One-Child Policy
An additional consequence of the one-child policy is the gender imbalance in the Chinese population. According to national statistics, the male to female ratio among newborns is 119 to 100.[49] In some areas, the ratio is as high as 130 males to 100 females.[50] This imbalance is exacerbated by and partially attributable to the traditional preference for male children as well as, particularly in rural areas, the practical advantages of having a male child.[51] This Committee, while recognizing that male children continue to be responsible for supporting older members of society, has encouraged the government to "take all appropriate measures to modify and eliminate son preference, *inter alia*, by expanding educational and employment opportunities for women in rural areas."[52] The government should institute systems that will provide financial support to the elderly who are otherwise financially dependent on their sons.

In turn, a particularly harmful and discriminatory effect of this preference for sons, in conjunction with the one-child policy, is the practice of sex-selective abortions.[53] Although sex-selective abortions are strictly prohibited,[54] there is evidence that the practice continues.[55] In addition, the ban on sex-selective abortions has largely been ineffective due to poor enforcement of laws that prohibit the practice.[56] According to the National Population and Family Planning Commission, only a small number of doctors have ever been charged for such practices.[57] In response to the continued practice of sex-selective abortions, a draft amendment to the criminal law was proposed that would criminalize the practice of sex-selective abortion by imposing penalties, probation and fines for individuals involved in "gender identification of embryos for non-medical purposes."[58] However, this amendment was recently rejected, thus increasing the likelihood that the practice will continue.[59]

This Committee has addressed the issue of sex-selective abortion in its Concluding Observations, urging the government to "enforce laws against sex-selective abortion, female infanticide and abandonment of children."[60] In addition to the CEDAW Committee, the Children's Rights Committee has expressed, in its Concluding Observations, that China should "strengthen its implementation of existing laws against selective abortions and infanticide and take all necessary measures to eliminate any negative consequences arising from family planning policies, including abandonment and non-registration of children and unbalanced sex ratios at birth."[61] In light of these recommendations, it is crucial that the government not only enforce such laws, but also directly address practices, such as the identification of fetal sex, that may be used as the basis upon which to decide to undergo a sex-selective abortion. Other causal factors including the traditional beliefs that fuel the desire for male children and policies and practices that do indeed offer advantages to families with sons and to those who comply with the one-child law must be simultaneously recognized and addressed as part of a broader strategy to promote respect for girls and to protect them against discrimination.[62]

An additional consequence of the one-child policy and the interrelated issues of gender imbalance and the practice of sex-selective abortions, is that women are subjected to violence which involves gross violations of basic human rights. For example, as a result of the shortage of females, trafficking of girls has increased.[63] These girls are sold as servants or brides.[64] There have been reports of the kidnapping, abduction and subsequent sale of women to rural villages, where, among other factors, the imbalance in the male-female sex ratio contributes to the scarcity of marriageable women[65] (similarly, there have also been reports of the abduction of boys because of the preference for boys over girls[66]). Additionally, "the scarcity of females has resulted in … increased numbers of commercial sex workers, with a potential resultant rise in human immunodeficiency virus infection and other sexually transmitted diseases."[67] Although the government prohibits trafficking of women,[68] according to official government figures, 10,000 women and children are trafficked each year in China.[69] On a related note, according to UNICEF, cross-border trafficking is increasing, such that "if current trends continue, China could soon become Asia's trafficking hub."[70] Additionally, while the law does prohibit practices of abduction, trafficking and kidnapping, the law "fails to provide any measure of penalties and remedies."[71] Thus, the potential of the law is severely limited.

The harmful effects of the one-child policy on women should be studied and acknowledged by the Chinese government. In addition to the suggestions made above, it is critical that some of the values that underlie practices such as sex-selective abortions be transformed, for example such that respect for women and for equality between the

genders is promoted and advanced as a cultural norm. It should be recognized that women's reproductive rights – such as their right to provide full informed consent before undergoing an abortion or sterilization – are integrally related to other rights, including political rights, social rights, economic rights and cultural rights. Thus, for women's rights to be fully realized, their involvement and participation must be actively sought. Finally, in instances in which laws to protect women's health and prevent abuses of authority are in place, the government must strictly enforce these laws.

C. Disproportionately High Proportion of Sterilized Women

In past Concluding Observations, this Committee has expressed general concern that family planning and contraception are still primarily the responsibility of women.[72] It has stressed that contraception and family planning responsibilities should be shared between women and men.[73] In particular, in relation to China, this Committee has expressed concern about the fact "that only 14 per cent of men use contraceptives, thus making contraception and family planning overwhelmingly a woman's responsibility."[74] The Committee has further stated that "in the light of the fact that vasectomy is far less intrusive and costly than tubal ligation, targeting mainly women for sterilization may amount to discrimination."[75] As a result of this concern, the Committee has urged the government "to promote information, education and counselling, in order to underscore the principle of reproductive choice, and to increase male responsibility in this regard."[76]

Currently, the rate of sterilization among females is significantly higher than the rate among males, suggesting that the responsibility for contraceptive use is unevenly placed on females. According to data from one study that involved men and women in rural counties in three provinces, it was found that in the province of Jiangsu, the rate of female sterilization was 9.4% compared to a 0.6% male sterilization rate.[77] Nationally, the prevalence of sterilization among couples is 35.9% female to 10.2% male.[78] Among twenty countries with the highest prevalence of female sterilization among women who are married or in union, China's prevalence rate of 35.9% ranked fourth.[79] In contrast, while China was also on the list of the twenty countries with the highest prevalence of male sterilization, the prevalence rate of 10.2% ranked seventh, significantly lower than the rate among women.[80] The absolute number of female sterilization users in China is 86 million, which, together with India, accounts for the majority of the 147 million female sterilization users in Asia, the continent with the highest number of female sterilization users.[81] Furthermore, sterilization as a percentage of overall contraceptive prevalence is 54.5%, which, among nineteen countries in Asia, is the fifth highest rate.[82] The high incidence of female sterilization, despite widespread and affordable[83] contraceptive use – 84.6% of women in the reproductive age group use modern contraceptive methods[84] – indicates a continuing expectation for women to undertake the burden of family planning. For example, in interviews conducted with women from Beijing who underwent abortions, as well as their partners, it was discovered that more than half of the 100 men interviewed expressed that "they did not concern themselves with it [contraception] because it was 'women's business' and women should undertake the responsibility."[85] The interviews also revealed that, "to some extent, male indifference in matters related to fertility control is a consequence of the family planning programme's exclusive attention to women, and the non-availability of contraceptive services directed at men."[86] For example, both men and women expressed that family planning services for men were not available in their communities and that even male-specific methods, such as the condom, are generally made available to women, as opposed to men.[87]

It is crucial that the government ensure that a wide variety of contraceptive methods are made readily available to both men and women. Furthermore, efforts should be taken in the form of educational and counseling efforts such that men are aware of the critical need to take responsibility for using contraception, particularly in light of the fact that the "Population and Family Planning Law" mandates that "husbands and wives bear equal responsibility for family planning."[88] Efforts should also be made such that women are able to communicate to their partners that responsibility for contraception must be jointly shared.

D. Limited Access to Infertility Treatment

In past Concluding Observations, this Committee has expressed concern about a woman's access to reproductive health services and information, characterizing lack of access as constituting a form of discrimination against women.[89] Specifically, in its General Recommendation 24, this Committee has stated the obligation of States parties to "refrain from obstructing action taken by women in pursuit of their health goals."[90] By placing restrictions on access to assisted reproductive technologies (ART) in China, the government prevents women from the full realization of their fertility goals.

In 2001, the Ministry of Health implemented regulations concerning ART. Specifically, these regulations banned surrogate motherhood, defined as the use of technology on the part of doctors and medical offices "to help clients borrow the abdomen of another to have a baby."[91] The regulations also include laws regarding sperm collection – specifically, the requirement that sperm banks register with the Health Ministry, that donors be "carefully screened," that the age of donors be limited to those between 22 and 45 years of age, that donor files be cross-checked, that an individual man's sperm be distributed to only five women and, finally, that each sperm bank provide clear information about the use of the sperm to donors and clients.[92] Additional laws include eligibility criteria for ART services: eligible couples are those "with infertility, a family history of genetic diseases, sexually transmissible infections, or other physiological ailments preventing natural conception."[93] Additionally, single women are ineligible for ART services.[94]

The ineligibility of single women to access ART services is a form of explicit discrimination based on marital status, a form of discrimination which this committee has identified as an obstacle to accessing contraception.[95] In addition, while a certain degree of regulation is warranted, the multiple eligibility requirements for ART services create many obstacles for women seeking to access ARTs, potentially leading to discrimination, in direct contravention of the Population and Family Planning Law, according to which "discrimination against and mistreatment of women who suffer from infertility [is] prohibited."[96] In addition, restrictive laws on ART services can result in harm to women's health. According to one study, infertility caused anxiety and depression in 83.3% of the 130 infertile Chinese women studied.[97] Without the opportunity to utilize ART services, the well-being of women is put at risk.

An important component of the promotion and advancement of women's reproductive rights is the provision of services and treatments that allow women to achieve reproductive health and well-being. The government should therefore ensure that ART services are made more available to women by removing some of the existing regulations, such that they are able to achieve maximum reproductive health.

E. Maternal Mortality

In past Concluding Observations, the Committee has frequently expressed concern over high maternal mortality rates.[98] The Committee has even framed maternal morality as a violation of a woman's right to life.[99] Among other recommendations, the Committee has specifically recommended that States Parties increase access to reproductive health services[100] and ensure that births are attended by trained personnel.[101] Particularly relevant to China is the fact that this Committee has emphasized the needs of rural women in relation to the additional steps that states parties should take to ensure that this especially vulnerable population is able to access the right to health care.[102] In addition, in its General Recommendation on Women and Health, this Committee stresses that States parties must "take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care," and that "studies such as those that emphasize the high maternal mortality and morbidity rates worldwide… provide an important indication for States parties of Possible breaches of their duties to ensure women's access to health care."[103] The Committee recommends that States parties "reduce maternal mortality rates through safe motherhood services and prenatal assistance."[104]

Reducing maternal mortality, particularly in rural regions of the country, must necessarily involve efforts aimed at lessening and eventually eliminating the financial disparities that exist between urban and rural areas as well as efforts to increase overall access to health care.

It has been speculated that China's "urban-rural income inequality is perhaps the highest in the world."[105] Relatedly, those living in rural areas are less likely to have access to medical services for a variety of reasons.[106] One underlying reason for the lack of access to health care services is the lack of funding and particularly the great discrepancies in health care funding between regions. According to 2002 figures, on average, per-capita spending in urban areas was double the amount of spending nationally.[107] A comparison of spending between urban and rural areas revealed that the amount of spending in urban areas was 3.5 times the amount in rural areas.[108] While the total health expenditure for 500 million urban residents was RMB 280 billion, the expenditure for 800 million rural residents was only RMB 190 billion.[109] The highly decentralized manner in which the system for financing public health services is structured further contributes to funding discrepancies, as poorer regions do not have the necessary funding to finance basic public services.[110] Further, health resources tend to be concentrated in large or medium-sized cities because funding tends to be allocated to hospitals in such areas.[111] According to estimates for eastern, central, and western regions of China, "total health care funding of developed eastern provinces was larger than that of central and western regions, both in terms of total volume and of per capita funding."[112] As a result, in such regions, individuals must pay for 50-60 percent of their health care.[113] This, coupled with the fact that "the proportion of persons with no medical insurance increased from 27.3 percent in 1993 to 44.8 percent in 2003,"[114] results in a situation in which health care services are not affordable and are thus inaccessible to those without the financial means to pay for medical services. Such a situation results in "a heavy burden for residents of relatively poorer central and western areas."[115] A study of the average cost of pregnancy delivery at hospitals in five rural counties revealed that with the exception of Guizhou province, the average cost in Gansu, Ningxia, Qinghai and Xinjiang was over 400 RMB, which

amounts to half of a person's yearly income.[116] Most rural women cannot afford this cost which, in reality, is even higher because of transportation fees and accommodation expenses.[117] Additional reasons that contribute to the lack of access to health care include the fact that clinics do not even exist in some poor and mountainous areas, that the number of health personnel in rural areas has declined, and that the physical distance between people's homes and hospitals prevents access.[118]

A comparison of maternal mortality rates over time demonstrates that the overall rate has been decreasing. The rate has fallen from 63.6 deaths per 100,000 live births in 1997, to 53 deaths in 2000, to 50.20 deaths in 2001, and to 43.2 deaths in 2002.[119] However, great regional disparities exist. In discussing China's progress towards accomplishing the Millennium Development Goals, including the goal to reduce the maternal mortality ratio by three-quarters by 2015, it has been noted that "nationwide statistics mask substantial and growing differences between urban and rural areas and between the coastal region and the central and western regions."[120] Thus, "using national data to assess progress toward development goals can … yield misleading conclusions."[121] For example, a comparison of rural figures with national figures demonstrates the discrepancies in maternal mortality rates between rural women and women overall: the maternal mortality rate among rural women, while it has decreased over the years (from 98 deaths per 100,000 in 1992 to 58 deaths in 2000), is nevertheless "well above the national average."[122] According to 2004 figures, the maternal mortality rate in urban areas was 26.1 per 100,000 live births, as compared to 63 per 100,000 live births in rural areas.[123] Specific examples of this discrepancy include the following: according to 2002 figures, the maternal mortality ratio was 9.6 per 100, 000 live births in Shanghai, 111 in Guizhou, 130 in Qinghai, and a staggering 399 in Tibet.[124] Additionally, in 2000, while on the one hand maternal mortality rates in China's 12 eastern provinces were below the national average, among the central provinces, seven of the nine provinces had rates that were *above* the average.[125] Similarly, among the western provinces, nine of the ten provinces had rates that were *above* the national average (among these provinces, Inner Mongolia had an approximately average rate).[126]

A factor that contributes to the discrepancy in maternal mortality rates between rural and urban areas is the proportion of births that occur in hospitals, as hospital births have been shown to "substantially reduce" maternal mortality rates.[127] While the national rate for hospital births in 2002 was 79 percent, wide regional differences existed.[128] For example, rates in major cities were as high as 100 percent, while in Tibet and Guizhou the rate of hospital births was approximately one-third. The lowest hospital birth rates were found in western regions of the country.[129]

Aside from financial barriers, one study revealed that some women refused to deliver in hospitals even when doing so would be free.[130] Some reasons for women's hesitancy about delivering in hospitals include "the low social and economic status of women, culture and beliefs."[131]

It is crucial that greater efforts be made to continue to reduce maternal mortality rates, particularly in light of China's law on Maternal and Infant Health Care, according to which the State must "encourage and support education and scientific research in the field of maternal and infant health care, popularize the advanced and practical technique for maternal and infant health care and disseminate the scientific knowledge in this filed."[132] In particular, as the above statistics demonstrate, it is necessary, for purposes of reducing maternal mortality rates, to focus particular attention on rural areas.[133] Steps

that should be taken towards this goal include allocating increased funding and medical personnel to rural regions. Additional steps include examining factors that contribute to the regional disparities in maternal mortality rates, such as social and cultural factors. It is also necessary to investigate the causes of maternal deaths. For example, the fact that despite the high number of hospital deliveries and high rate of home births that are monitored by trained attendants, maternal deaths still occur suggests the need for further investigation.[134] It is also necessary to investigate the degree to which unsafe abortion contributes to maternal mortality, as some estimates reveal that the proportion of maternal deaths due to unsafe abortion in China exceeds the global average, which is 13 percent.[135] A necessary component of reducing maternal mortality rates is ensuring that maternal deaths are reported, particularly in light of a study that found underreporting of maternal deaths, particularly in rural areas where, in contrast to urban areas where "there is a good MCH (maternal and child health) network, good communication, and skilled supervision," barriers to reporting exist.[136] Again, reporting is particularly important in light of China's law on Maternal and Infant Health Care, according to which "Medical and health institutions and midwives engaged in home delivery shall, as prescribed by the administrative department of public health under the State Council … report to the administrative department of public health, if a lying-in woman … dies."[137]

F. Lack of Data on Abortion

In its Concluding Observations, the Committee has repeatedly recognized the importance of gathering disaggregated data on women's health needs as a necessary component of determining whether or not their right to health is being fulfilled.[138]

Currently, there is a lack of reliable and consistent data on the incidence of abortions performed in China. Abortion data is a necessary component in policymaking that deals with factors that influence rates of legal induced abortion worldwide.[139] Abortion data – particularly harm to women's health caused by unsafe abortion as well as rates of the incidence of abortion – in conjunction with other data on family planning services is also necessary for purposes of implementing the recommendation of the 1994 International Conference on Population and Development "to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services."[140]

In a 1995 study conducted on the incidence of abortion worldwide, information on abortion in China was considered to be "incomplete" or of an "unknown completeness."[141] The official rate in China was reported as 7,930,000 abortions, or 26.1 abortions per 1,000 women aged 15-44, or 27.4 abortions per 100 known pregnancies.[142] An additional study produced in 1999 that measured rates of legal induced abortion between 1975 and 1996 found that 1996 rates were unavailable.[143] A further inconsistency exists in that according to statistics from the Chinese State Family Planning Commission, four million abortions were performed in 1999,[144] which would mean that the number of abortions was reduced by almost 50 percent in the four years between 1995 and 1999.

Speculation that reported figures are lower than actual figures is based on several factors that lead to underreporting: the fact that approximately one million medical or mifepristone abortions occur every year and are not included in the figure; the incompleteness in reporting from family planning clinics; and the fact that while the family planning program collects statistics, these statistics are based on self-reporting on

the part of local meetings of women, they do not include unmarried women, and they fail to include abortions that occur in many city hospitals and provinces.[145]

Furthermore, abortion data is generally attributed to incomplete reporting.[146] Underreporting or incomplete reporting may be caused by the alleged practice of forced or coerced abortions. Forced abortions may not be recorded by health authorities because they are strictly prohibited by law.[147] However, as was discussed above in section IB, there are reported incidents of forced abortions in villages,[148] for the purpose of implementation of the one-child policy.

In order to implement policies with regard to the practice of abortion, statistics about abortion must accurately reflect the number of abortions that are performed. If the number of abortions is underreported, it must be determined how many abortions are not included in official figures and why. It must also be determined how many abortions are the result of contraceptive failure. For example, it has been shown that both contraceptive non-use and failure have led to abortion assuming a greater role in fertility control.[149] According to government statistics, 70 percent of abortions result from contraceptive failure.[150] This statistic demonstrates the need for greater education and promotion of contraception. Additionally, a study of approximately 600 women in Shanghai revealed that almost half of the induced abortions could have been prevented with the use of emergency contraception, suggesting the need for greater information about and promotion of emergency contraception, in particular.[151]

In addition, information should be gathered as to discrepancies in abortion rates among regions of the country – according to the State Family Planning Commission, abortion rates were generally higher in cities and towns, as opposed to rural areas, due to behavioral factors as well as because rural women travel to city hospitals to seek late-trimester abortions.[152] According to a study based on data from China's National Survey of Fertility and Birth Control, couples residing in urban areas are more likely to have an induced abortion in cases of contraceptive failure.[153] Specifically, while for rural women 45 percent of IUD failures will result in a live birth, for urban women, 5.6 percent of IUD failures will result in a live birth.[154]

Finally, it is important to collect statistics regarding different types of abortions – particularly, to determine the occurrence of coerced abortions and to ensure that this practice is brought to an end. Relatedly, it is critical that accurate information be gathered regarding the conditions under which abortions are performed, for purposes of ensuring that basic standards of quality of care are routinely met and to protect women's rights to free and informed consent, privacy, autonomy and dignity in the context of reproductive health care.

II. Information and Education on Sexuality (Articles 10(h), 12)

A. Adolescents Right to Information and Education on Sexuality

In its Concluding Observations, the Committee has often expressed general concern over women's access to reproductive health services and information.[155] The Committee has also specifically recognized that young women experience difficulty accessing reproductive health care.[156] It has recommended that States Parties provide family

planning services[157] and widely disseminate reproductive health and family planning information.[158]

The National Family Planning Programme targets married couples, as a result of which young people do not have access to information or advice regarding contraception.[159] The evidence demonstrates that Chinese youth (both high school and college students) are increasingly engaging in sexual behavior.[160] Relatedly, there has been an increase in induced abortion rates among young unmarried women, and evidence to suggest sexual coercion among those who seek abortions.[161] At the same time, sexual education, particularly those topics that are related to contraceptive methods and alternatives, are often excluded from school curricula due to fear on the part of teachers, policymakers and education administrators about inadvertently either endorsing or encouraging sexual activity.[162]

One study which examined the effects of a community-based comprehensive sexual education program targeted at unmarried youth between the ages of 15 and 24 in suburban Shanghai revealed that "consistent use of contraceptives increased over time among intervention participants and that these youth had higher levels of use of particular methods than their peers in the control group."[163]

It is crucial that, as the prevalence of sexual activity increases among young people, sex education programs be provided by schools to target this segment of the population. Specifically, such programs should include comprehensive sex education about a full range of sexual and reproductive health matters; the provision and distribution of contraception; sexual health counseling and treatment for STIs and HIV/AIDS; and training in negotiation and other skills relevant to the development of a healthy sexual relationship.[164] In addition, in order to protect low-income, rural or migratory women who may not be able to attend school, the government should provide access to comprehensive information and affordable treatment of their reproductive health through community based programs for adolescent girls and women.

B. Sexually Transmitted Infections (STIs) and HIV/AIDS

The CEDAW Committee has frequently expressed general concern over the prevalence of HIV/AIDS and other STIs.[165] It has requested that governments use a human rights-based approach to HIV/AIDS.[166] The Committee has also repeatedly recommended the use of general preventative measures;[167] awareness raising and education programs;[168] reproductive and sexual health education programs;[169] and promotion of condom use.[170] As for treatment, the Committee has expressed concern over the absence of care facilities for those infected with HIV/AIDS,[171] especially women and girls.[172] Further, the Committee has stressed the vulnerability of particular groups who are at greater risk of contracting HIV/AIDS,[173] including young adults,[174] trafficked women and girls,[175] and most frequently, sex workers.[176] It has commented frequently on the need for access to health services for sex workers.[177]

In addition, the Children's Rights Committee, in its 2005 Concluding Observations to China, recommended that efforts be made to eliminate discrimination against children who are either infected with or otherwise affected by HIV/AIDS and that efforts be made in general to implement policies and programmes for these children, including increased allocation of financial resources, public information campaigns, and prevention efforts.[178]

The total number of HIV infections in China – 840,000 – represents almost two-thirds of the total number of infections within the region of Asia and the Pacific.[179] Of this number, as of 2003, 80,000 cases were clinically confirmed AIDS cases.[180] The 840,000 HIV infections represent a 0.12% prevalence rate among those aged 15 – 49 years of age which, among twenty-eight Asian-Pacific countries, ranks as the tenth highest prevalence rate.[181] In addition, infection rates are much higher, even as high as 80% among injecting drug users, in certain geographic areas (such as Yunnan, Guangxi, Henan, Xinjiang and Guangdong provinces)[182] as well as among certain high-risk groups.[183] The increase in the reported number of HIV cases and AIDS cases has been tremendous: the number of new HIV cases has tripled each year since 2000[184] and there has been a 44% increase in AIDS cases between 2001 and 2002 and a 206% increase between 2000 and 2001.[185]

High rates of HIV transmission are also attributable to the following: heterosexual risk behaviors among the "mobile working population";[186] rural populations;[187] unmarried youth (most new infections occur among young people);[188] pregnant women and newborns, as a result of mother-to-child transmission (the mother-to-child transmission rate increased from 0.1% in 1997 to 1.0% in 2004);[189] gay men, among whom the rate is between 3% and 5%, and infection is primarily due to lack of knowledge as well as unsafe sex with multiple partners;[190] and women, as evidenced by the fact that between 1998 and 2004, the proportion of female to total HIV cases increased by more than two fold from 15.3% to 39.0%.[191]

Regarding modes of transmission, approximately 90% of HIV infections are due to transmission among injecting drug users (IDU) and HIV-contaminated plasma collection equipment.[192] Injecting drug users are the largest vulnerable population group, such that the spread of HIV in this population has been described as "explosive," with over three million people infected and HIV infection rates as high as 80% in some areas.[193] Based on estimates of the total number of IDU and HIV prevalence rates among IDU populations, it has been projected that until public health programmes are able to "fully and aggressively implement harm/risk reduction programmes," the number of HIV-infected IDU will double "during this decade."[194]

HIV infections among IDU as well as those who have been infected through plasma collection has in turn resulted in HIV transmission to regular sex partners, particularly because it has been found that risk behaviors among these groups continues to be high.[195] For example, the rates of sharing of injection equipment among IDUs range from 73% in Hunan, to 81% in Jiangxi to 100% in Xinjiang.[196] As a result of these risky behaviors, "the potential for epidemic heterosexual HIV transmission is present."[197]

An additional area of serious concern is HIV prevalence among children. At the end of 2001, the estimated number of HIV-positive children under 15 years of age was estimated at 3000.[198] Half of new infections in China occur in children or young people. In addition to HIV infection itself, children are also seriously impacted as a result of being orphaned as a result of HIV/AIDS deaths. For example, approximately 80,000 children under the age of 14 have been orphaned for this reason.[199] In certain regions of China, about 20 percent of those living with HIV/AIDS have children under five years of age.[200] Thus, the number of children orphaned by AIDS is expected to increase to 260,000 by the year 2010.[201]

Similarly worrisome is the increase in rates of STI infection. The number of reported cases increased from 5800 in 1985 to more than 836,000 in 1999.[202] Between 1987 and

1997, the number of new STI cases increased by more than nine fold to a rate of 37.3 infections out of 100,000 individuals.[203]

Regionally, in 1997, the incidence of STIs was highest in Shanghai, at 254.3 out of 100,000, after having increased by 32% annually between 1994 and 1997.[204] Problems that exacerbate the problem of STI infection include the fact that those who experience symptoms often self-treat, they consult providers who are not trained, and they postpone seeking effective care.[205] The reason for some of these problems include poor knowledge about STIs, misperceptions regarding services, fear of being stigmatized, and poor access.[206]

The factors that have contributed to the increased prevalence of HIV are similarly serious and problematic. These factors include low overall awareness of HIV/AIDS and even lack of awareness about HIV status;[207] high levels of stigma and discrimination towards individuals with HIV/AIDS; high rates of mobility and migration;[208] the availability and affordability of commercial sex among both heterosexual and homosexual populations, particularly in coastal regions of East and South China as well as in large cities;[209] and, low rates of condom use.[210] Similarly, the response to HIV/AIDS has been problematic and inadequate. For example, the public health sector is limited in its ability to treat HIV/AIDS and implement policies at the local level;[211] human resources are unavailable;[212] community support mechanisms for counseling are not readily available;[213] access to voluntary testing and counseling is limited;[214] capacity to deliver antiretroviral capacity is limited because there are not enough available trained health care staff and because of infrastructure shortages;[215] free services to low-income people in rural areas who lack health care insurance are lacking;[216] and, there are difficulties reaching the most marginalized and vulnerable groups.[217]

In order to respond to HIV/AIDS, a "comprehensive, long-term nationwide plan" should be developed[218] that includes participation and commitment from sectors, including those outside of the Ministry of Health.[219] In addition, voluntary testing and counseling centers should be established for the purpose of identifying HIV infected persons and for evaluating the HIV status of their sex partners.[220] Education must be a central component of any efforts, for example in the form of information campaigns.[221] Health education, particularly regarding prevention, is particularly crucial considering the fact that a 2004 survey revealed that 80 percent of high schools had never participated in a course or in any activities related to HIV prevention.[222] Further, those individuals and groups who are most vulnerable and most difficult to reach should be targeted – for example, outreach should be conducted to injecting drug users, sex workers, and mobile populations.[223] Further, programs that specifically target HIV/AIDS among women, including pregnant women, should be established, and any existing programs must be strengthened. An essential element of any such program must include the provision of information regarding treatment options that seeks to optimize women's own health conditions. Once a woman is provided with this information, she must have the freedom to determine a course of action that she deems to be in her own best interest and in the interest of her newborn child. In addition, comprehensive policies for children affected by HIV/AIDS must be established.[224] Clinics should ensure privacy, stress positive interaction with clients, and integrate various services, including education, treatment, counseling and condom promotion.[225] In order to promote condom use, any local regulations that limit condom availability in clinics and hospitals should be removed and condoms should be promoted in various types of programs, including family planning and primary health care.[226] As a result of the fact that family planning programs have tended to focus on

women, couples often use methods that do not protect against STIs and HIV. Thus, women are placed at risk, particularly when their partners engage in unprotected casual sex.[227] Therefore, these programs must focus on the responsibility of both men and women to use family planning methods that protect against STIs and HIV. Policies that denounce HIV/AIDS discrimination should be enforced and strengthened, particularly because violations of such anti-discrimination policies are only minimally punishable.[228] Finally, community participation should be a component of efforts to increase access to antiretroviral therapy and to reduce fear, social stigma and discrimination towards those living with HIV/AIDS.[229]

III. Right to Freedom from Discrimination (Articles 1, 2, 3); Discrimination against Women in Rural Areas (Art. 14)

In the early 1990s, the number of individuals that make up the "floating population," consisting of temporary or seasonal workers who migrate from rural areas to large industrial cities, was estimated to be between 70 and 80 million.[230] Of this number, about one third were women, though in some cities, the percentage of women was higher (for example, 50 percent in Guangzhou and 70 percent in Taiyuan).[231] Among this female population of migrant workers, half were below the age of 25.[232] In addition, it is estimated that 19 million children accompany their migrating parents.[233]

When a study was conducted that involved focus group discussions and interviews with migrant workers as well as individuals in various occupations who work with migrant workers, it was found that knowledge about as well as use of contraceptives was low.[234] For example, even among those women who identified as being sexually active, most had never used contraception nor did they know where it could be obtained.[235] Interviews with providers of family planning services revealed that migrant women were more likely than non-migrant women to delay undergoing an abortion, they were more likely to experience multiple abortions, and they were more likely to seek abortions from private providers who tended to be less qualified.[236] Additional factors that impacted upon the low level of knowledge about and use of contraception among the migrant population included social and cultural factors, such as embarrassment about obtaining contraceptives or the lack of negotiating power in relationships with sexual partners.[237]

It is crucial that this population receive necessary information and services with regard to sexual and reproductive health and that they not be discriminated against as a result of their status as migrant individuals. Based on the above study, it was recommended that greater efforts be made to ensure that family planning programs and information materials be made available to migrant women.[238] In addition, particularly when migrant women first arrive in cities, they should be provided with family planning information, including information as to where to obtain services.[239] Employers should play a role in disseminating information and in providing reproductive health services in medical clinics based at the workplace.[240] Finally, information and services should be provided through visits to workplaces where migrants are heavily concentrated by urban family planning workers.[241]

We hope that the Committee will consider addressing the following questions to the government of China:

1. What steps is the Chinese government taking to ensure that coercion and violence are strictly prohibited and sanctioned in the content and enforcement of family planning laws?
2. How is the Chinese government monitoring enforcement of the one-child policy such that women are not harmed, particularly through forced abortions and forced sterilization? How is the government ensuring that a woman's informed consent is always obtained prior to an abortion or sterilization procedure?
3. How are officials monitored, to ensure that they do not exceed their authority in enforcing the one-child policy?
4. What steps are being taken to strictly enforce the prohibition on sex-selective abortions? What steps is the Chinese government taking such that the sexually discriminatory values and practices that result in sex-selective abortion are eliminated?
5. What steps are being taken to address the problems associated with the one-child policy, such as the resulting gender imbalance that contributes to the trafficking, kidnapping, abduction and sale of women?
6. How is the government ensuring that both men and women take responsibility for contraceptive use, such that sterilization rates among women are not disproportionately high, in comparison to men?
7. What steps are being taken to ensure that women suffering from infertility, including single women, are not unfairly denied access to assisted reproductive technology (ART) treatment?
8. What steps are being taken to reduce maternal mortality rates, particularly in the rural population? Is the government addressing both financial and non-financial factors that contribute to high maternal mortality rates among the rural population?
9. How is the government ensuring that reliable data is gathered regarding abortion rates, including discrepancies in rates throughout the country and also the incidence of coerced abortions?
10. Are comprehensive sexual education programs being created that target young people, including young people who are not able to attend school, particularly in light of increasing sexual activity among young people?
11. What steps are being taken, including preventative measures, educational efforts, and health education, including the promotion of condoms, in order to address STIs and HIV/AIDS? In addition, what steps are being taken in this regard to target the most vulnerable and most susceptible members of society, including pregnant women, to ensure that they are provided with information regarding their own health and treatment options, and that they have the freedom to choose the course of action that is in their own best interests? Finally, also in this regard, how are anti-discrimination policies being enforced?
12. How is the government addressing reproductive rights issues among migrant populations?

We appreciate the active interest that the Committee has taken in reproductive health and rights and the strong Concluding Observations and General Recommendations the Committee has issued to governments in the past, stressing the need for governments to take steps to ensure the realization of these rights. We hope that this information is useful during the Committee's review of China's compliance with the provisions contained in the Convention. A significant amount of information contained in this letter is from our 2005 publication, entitled "Women of the World: East and Southeast Asia," specifically the chapter detailing

laws and policies in China, which can be found online at http://crlp.org/pdf/China.pdf. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Very truly yours,

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Melissa Upreti
Legal Adviser for Asia
Center for Reproductive Rights
USA

[1] Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 39/46, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981).
[2] Committee on the Elimination of Discrimination against Women (CEDAW Committee), General Recommendation 24*, Women and Health*, art. 12, para. 1, U.N. Doc. A/54/38/ (Part I) (1999) [hereinafter General Recommendation 24].
[3] *Id.* at para. 2.
[4] *Id.* at para. 14.
[5] *Id.* at para. 31 (b).
[6] *Id.* at para. 31 (c).
[7] *Id.* at para. 31 (e).
[8] Committee on the Elimination of Discrimination against Women (CEDAW Committee), General Recommendation 19, *Violence against women*, para. 24 (m), U.N. Doc. A/47/38 (1992) [hereinafter General Recommendation 19].
[9] Committee on the Elimination of Discrimination against Women (CEDAW Committee), General Recommendation 21, *Equality in marriage and family relations*, para. 44, U.N. Doc. A/49/38 (1994) [hereinafter General Recommendation 21].
[10] *Consideration of reports submitted by States parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)*, *Combined fifth and sixth periodic report of States parties*, *China*, CEDAW Committee, Part II, 43 – 48, U.N. Doc. CEDAW/C/CHN/5-6.
[11] *Id.* at 43, 46, 47.
[12] Population and Family Planning Law of the P.R.C., Presidential Order No. 63, art. 18 (2001) (effective Sept. 1, 2002).
[13] *Id.*
[14] CENTER FOR REPRODUCTIVE RIGHTS & ASIAN-PACIFIC RESOURCE CENTER FOR WOMEN, WOMEN OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES, EAST AND SOUTHEAST ASIA 41, (2005), *available at* http://crlp.org/pdf/China.pdf [hereinafter WOMEN OF THE WORLD].
[15] Population and Family Planning Law, *supra* note 12, at arts. 18, 41.
[16] WOMEN OF THE WORLD, *supra* note 14, at 51.
[17] Population and Family Planning Law, *supra* note 12, at art. 41.
[18] WOMEN OF THE WORLD, *supra* note 14, at 51.
[19] *Id.*
[20] *Id.* at 41.
[21] Elina Hemminki et al., *Illegal births and legal abortions – the case of China*, 2 REPRO. HEALTH JNL. 5 (2005), *available at* http://www.reproductive-health-journal.com/content/2/I/5.
[22] WOMEN OF THE WORLD, *supra* note 14, at 51.

[23] *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: China*, 20th Sess., 419th to 421st mtg., para. 300, U.N. Doc. CEDAW/A/54/38 (1999) [hereinafter *Concluding Observations of CEDAW: China*].
[24] *Id.*
[25] *Id.*
[26] Si-Si Lu, *Where Have All the Young Girls Gone?*, 4 CHINA RIGHTS FORUM (2004) 50, *available at* http://www.hrichina.org/fs/view/downloadables/pdf/downloadable-resources/YoungGirls4.2004.pdf.
[27] General Recommendation 19, *supra* note 8, at para. 22.
[28] *Id.* at para. 24 (m).
[29] General Recommendation 21, *supra* note 9, at para. 22.
[30] General Recommendation 24, *supra* note 2, at para. 22.
[31] *Id.*
[32] *Id.* at para. 31 (e).
[33] *Concluding Observations of CEDAW: China*, *supra* note 23, at para. 299b.
[34] *Id.*
[35] *Id.* at para. 300.
[36] *Id.*
[37] *Concluding Observations of the Committee on Economic, Social and Cultural Rights: People's Republic of China (including Hong Kong and Macao)*, 34th Sess., 27th mtg., para. 36, U.N. Doc. CESC/E/C.12/1 Add.107.
[38] *Id.*
[39] *Id.* at para. 65. Article 10 of the International Covenant on Economic, Social and Cultural Rights states the following: The States Parties to the present Covenant recognize that: 1. The widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of dependent children. Marriage must be entered into with the free consent of the intending spouses. 2. Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits. 3. Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions. Children and young persons should be protected from economic and social exploitation. Their employment in work harmful to their morals or health or dangerous to life or likely to hamper their normal development should be punishable by law. States should also set age limits below which the paid employment of child labour should be prohibited and punishable by law.
[40] Regional Office for Europe, World Health Organization (WHO), *A Declaration on the Promotion of Patients' Rights in Europe*, European Consultation on the Rights of Patients, Mar. 28-30, 1994, at para. 3.1, WHO Doc. EUR/ICP/HLE 121 (1994).
[41] BUREAU OF DEMOCRACY, HUMAN RIGHTS, AND LABOR, U.S. DEPARTMENT OF STATE, COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES 2004: CHINA (2005), *available at* http://www.state.gov/g/drl/rls/hrrpt/2004/41640.htm (Released Feb. 28, 2005) [hereinafter COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES 2004: CHINA].
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] *Id.*
[46] Regulations on Administration of Technical Services for Family Planning, Decree No. 309, arts. 3, 14, (2001) (effective Oct. 1, 2001).
[47] Law on Maternal and Infant Health Care, Presidential Order No. 33, art. 19 (1994) (effective June 1, 1995).
[48] COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES 2004: CHINA, *supra* note 41.
[49] WOMEN OF THE WORLD, *supra* note 14, at 50.
[50] China Daily, *Checking Imbalance in Gender Ratio* (May 26, 2004), *at* http://www.chinadaily.com.cn/english/doc/2004-05/26/content_333951.htm. According to the fifth national census conducted in 2000, the highest gender imbalance was found in the Guangdong and Hainan

provinces and the Guangxi Zhuang Autonomous Region with a male to female ratio of 130 to 100, respectively. *Id.*

[51] Maureen J. Graham et al., *Son Preference in Anhui Province, China*, 24 INT'L FAMILY PLANNING PERSPECTIVES 72-77, 72 (1998), *available at* http://www.guttmacher.org/pubs/journals/2407298.html. *See* also Si-Si Lu, *supra* note 26.

[52] *Concluding Observations of CEDAW: China*, *supra* note 23, at para. 301.

[53] Hemminki et al., *supra* note 21.

[54] Regulations on Administration of Technical Services for Family Planning, *supra* note 46, at art. 15. The use of sex-identifying techniques such as ultrasonography are "strictly prohibited" for non-medical purposes. Sex-selective terminations are also "strictly prohibited." *See also* Population and Family Planning Law, *supra* note 12, at art. 35. Institutions and individuals are forbidden from conducting fetal sex identification for non medical reasons and performing sex-selective terminations.

[55] COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES 2004: CHINA, *supra* note 41. One official study conducted in the Hainan Province indicated that 68% of abortions were of female fetuses. In a 2002 survey of one rural township, 35% of the women admitted to having had a sex-selective abortion. *See* Therese Hesketh et al., *The Effect of China's One-Child Family Policy after 25 Years*, 353 N. Engl. J. Med. 1171-1176 (2005). Although actual figures on the incidence of sex-selective abortions are hard to obtain due to the illegality of the practice, it is known to be "widely carried out, helped by a burgeoning private sector." *Id.*

[56] COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES 2004: CHINA, *supra* note 41.

[57] *Id.*

[58] China Daily, *China Unlikely to Criminalise Selective Abortions* (June 25, 2006), *at* http://english.people.com.cn/200606/25/eng20060625_277174.html.

[59] *Id.* The amendment was rejected due to concerns by some lawmakers and the National Population and Family Planning Commission about the potential for driving sex-selective abortion offenders underground, making it more difficult to gather evidence on illegal sex-selective abortions. Opponents of the amendment also argued that pregnant women had a right to know the sex of the fetus and that criminalization of the use of ultrasounds for this purpose was excessive. Further, the imbalanced gender ratio was attributed to the societal preference for sons and it was expressed that this would not be affected through such a law.

[60] *Concluding Observations of CEDAW: China*, *supra* note 23, at para. 301.

[61] *Concluding Observations of the Committee on the Rights of the Child (CRC): China*, 40th Sess., 1080th mtg., para. 29, U.N. Doc. CRC/C/CHN/CO/2 (2005) [hereinafter *Concluding Observations of CRC: China*].

[62] Si-Si Lu, *supra* note 26; China Daily, *Checking Imbalance in Gender Ratio*, CHINA DAILY, *supra* note 50; Maureen J. Graham et al., *supra* note 51; Karen Hardee et al., *Family Planning and Women's Lives in Rural China*, 30 (2) INT'L FAMILY PLANNING PERSPECTIVES 68-76 (2003), *available* at http://www.guttmacher.org/pubs/journals/3006804.html.

[63] COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES 2004: CHINA, *supra* note 41; Si-Si Lu, supra note 26, at 51; Therese Hesketh et al., *supra* note 55, at 1173.

[64] Si-Si Lu, *supra* note 26, at 51.

[65] COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES 2004: CHINA, *supra* note 41.

[66] Si-Si Lu, *supra* note 26, at 52.

[67] Therese Hesketh et al., *supra* note 55, at 1173.

[68] Law on the Protection of Rights and Interests of Women, Presidential Order No. 58, art. 36, (1992) (effective Oct. 1, 1992). The law prohibits abduction, trafficking, kidnapping, and sale of abducted or trafficked women. Also, governments have a duty to "take timely measures to rescue" abducted, trafficked, or kidnapped women. *Id.*

[69] United Nations International Children's Emergency Fund (UNICEF) China, Protection and Community Services: Trafficking of Children and Women, (last visited July 7, 2006), *available at* http://www.unicef.org/china/protection_community_484.html.

[70] *Id.*

[71] Si-Si Lu, *supra* note 26, at 52.

[72] CENTER FOR REPRODUCTIVE RIGHTS & UNIVERSITY OF TORONTO PROGRAMME OF REPRODUCTIVE AND SEXUAL HEALTH LAW. BRINGING RIGHTS TO BEAR: AN ANALYSIS OF THE WORK OF UN TREATY MONITORING BODIES ON REPRODUCTIVE AND SEXUAL RIGHTS 125 (2002) [hereinafter BRINGING RIGHTS

TO BEAR]. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.*, **Bangladesh**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 438; **China**, 03/02/99, U.N. Doc. A/54/38, ¶¶ 299 (a); **India**, 01/02/2000, U.N. Doc. A/55/38, ¶ 78; **Vietnam**, 31/07/2001, U.N. Doc. A/56/38, ¶ 266.

[73] *Id*. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.*, **Bangladesh**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 438; **Belarus**, 31/01/2000, U.N. Doc. A/55/38, ¶ 374; **Belize**, 01/07/99, U.N. Doc. A/54/38, ¶ 57; **Burkina Faso**, 31/01/2000, U.N. Doc. A/55/38, ¶ 276; **Chile**, 31/05/95, U.N. Doc. A/50/38, ¶ 139; **China**, 03/02/99, U.N. Doc. A/54/38, ¶¶ 299 (a), 300; **Colombia**, 04/02/99, U.N. Doc. A/54/38, ¶ 396; **Greece**, 01/02/99, U.N. Doc. A/54/38, ¶ 208; **Indonesia**, 14/05/98, U.N. Doc. A/53/38, ¶ 280; **Mongolia**, 02/02/2001, U.N. Doc. A/56/38, ¶ 274; **Nicaragua**, 31/07/2001, U.N. Doc. A/56/38, ¶ 303; **Slovenia**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 119; **United Kingdom of Great Britain and Northern Ireland**, 01/07/99, U.N. Doc. A/54/38, ¶ 310.

[74] *Concluding Observations of CEDAW: China*, *supra* note 23, at para. 299a.

[75] *Id.*

[76] *Id.* at para. 300.

[77] Karen Hardee et al., *supra* note 62, TABLE 2: Selected measures of Chinese women's contraceptive use, by province, *available* at http://www.guttmacher.org/pubs/journals/3006804.html. The study examined contraceptive use in three provinces: Jiangsu, Anhui, and Yunnan. The greatest difference in male to female sterilization use was in Jiangsu, where 9.4 percent of females were sterilized as compared to 0.6 percent of males. The overall rate of contraceptive use was 97.1 percent. In Anhui, 30.5 percent of females were sterilized, as compared to 28.7 percent of males. The overall contraceptive prevalence rate in Anhui was 90.6 percent. In Yunnan, 28.9 percent of females were sterilized, as compared to 12.1 percent of males. In Yunnan, the overall contraceptive rate was 86.6 percent. These statistics demonstrate that in all three provinces, there was a higher incidence of female sterilization, as compared to male sterilization. *Id.*

[78] ENGENDERHEALTH, CONTRACEPTIVE STERILIZATION: GLOBAL ISSUES AND TRENDS, 30-31, (2002), TABLE 2.3: Twenty countries with the highest prevalence of female sterilization among women who are married or in union, by country and year of survey, TABLE 2.4: Twenty countries with the highest prevalence of male sterilization among women who are married or in union, by country and year of survey.

[79] *Id.* at 30, TABLE 2.3.

[80] *Id.* at 31, TABLE 2.4.

[81] *Id.* at 33.

[82] *Id.* at 55 (Supp. 2.5).

[83] Regulations on Administration of Technical Services for Family Planning, *supra* note 46, at art. 3. Contraceptive and birth control techniques are to be provided by the State, free of charge, to married couples in rural areas who practice family planning and are of reproductive age. Any necessary expenses will be covered by the local financial budgets and the central financial department will offer "reasonable subsidies" to western areas "in difficulties." *Id.*

[84] World Health Organization (WHO), Regional Office for the Western Pacific, China: Health Databank (2004), *available at* http://www.wpro.who.int/NR/rdonlyres/F838F10C-4EC5-49C5-BFFB-07651558FBEA/0/chn_hdb.pdf (Last visited June 30, 2006). This 2002 estimate was provided by the Ministry of Health.

[85] Xiao Yang et al., *Determinants of Unwanted Pregnancy and Abortion in Beijing, China*, 5 REPRO. HEALTH MATTERS 95, 98, 1995, *available at* http://download.journals.elsevierhealth.com/pdfs/journals/0968-8080/PII096880809590087X.pdf.

[86] *Id.* at 99.

[87] *Id.* Furthermore, it is women who tend to be punished for not keeping within birth targets.

[88] Population and Family Planning Law, *supra* note 12, at art. 17.

[89] BRINGING RIGHTS TO BEAR, *supra* note 72, at 105. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.*, **Antigua and Barbuda**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 258; **Bangladesh**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 438; **Belize**, 01/07/99, U.N. Doc. A/54/38, ¶¶ 56-57; **Burkina Faso**, 31/01/2000, U.N. Doc. A/55/38, ¶ 274; **Croatia**, 14/05/98, U.N. Doc. A/55/38, ¶ 109; **Cuba**, 09/05/96, U.N. Doc. A/51/38, ¶ 219; **Ethiopia**, 09/05/96, U.N. Doc. A/51/38, ¶ 160; **Georgia**, 01/07/99, U.N. Doc. A/54/38, ¶ 111; **Greece**, 01/02/99,

U.N. Doc. A/54/38, ¶¶ 207-208; **Guinea**, 31/07/2001, U.N. Doc. A/56/38, ¶¶ 128-129; **Guyana**, 31/05/95, U.N. Doc. A/50/38, ¶ 621; **Hungary**, 09/05/96, U.N. Doc. A/51/38, ¶ 254; **Iraq**, 14/06/2000, U.N. Doc. A/55/38, ¶¶ 203-204; **Kazakhstan**, 02/02/2001, U.N. Doc. A/56/38, ¶¶ 105-106; **Lithuania**, 16/06/2000, U.N. Doc. A/55/38, ¶¶ 158-159; **Mongolia**, 02/02/2001, U.N. Doc. A/56/38, ¶ 267; **Morocco**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 68; **Nicaragua**, 31/07/2001, U.N. Doc. A/56/38, ¶¶ 300-301, 303; **Nigeria**, 07/07/98, U.N. Doc. A/53/38/Rev.1, ¶¶ 170-171; **Paraguay**, 09/05/96, U.N. Doc. A/51/38, ¶ 123; **Peru**, 08/07/98, U.N. Doc. A/53/38/Rev.1, ¶¶ 337, 341; **Republic of Moldova**, 27/06/2000, U.N. Doc. A/55/38, ¶¶ 109-110; **Romania**, 23/06/2000, U.N. Doc. A/55/38, ¶¶ 314-315; **South Africa**, 30/06/98, U.N. Doc. A/55/38/Rev.1, ¶ 134; **Venezuela**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 236; **Vietnam**, 31/07/2001, U.N. Doc. A/56/38, ¶ 266; **Zimbabwe**, 14/05/98, U.N. Doc. A/53/38, ¶ 148.

[90] General Recommendation 24, *supra* note 2, at para. 14.

[91] Kaiser Network, *China to Outlaw 'Surrogate Motherhood,' Restrict Sperm Donations* (Mar. 21, 2001), *at* http:// http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=2&DR_ID=3550.

[92] *Id.*

[93] WOMEN OF THE WORLD, *supra* note 14, at 39.

[94] *Id.*

[95] BRINGING RIGHTS TO BEAR, *supra* note 72. This is supported by the Committee's Concluding Observations to the following country as cited in this publication. *See e.g.*, **Mauritius,** 31/05/95, U.N. Doc. A/50/38, ¶211.

[96] Population and Family Planning Law, *supra* note 12, at art. 22.

[97] Fatemeh Ramezanzadeh et al., *A Survey of Relationship Between Anxiety, Depression and Duration of Infertility*, 4 BMC WOMEN'S HEALTH 9 (2004), *available at* http://www.biomedcentral.com/1472-6874/4/9.

[98] BRINGING RIGHTS TO BEAR, *supra* note 72, at 107. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.*, **Antigua and Barbuda**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 260; **Argentina**, 23/07/97, U.N. Doc. A/52/38 Rev.1, Part II, ¶ 304; **Australia**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 397; **Azerbaijan**, 14/05/98, U.N. Doc. A/53/38, ¶ 63; **Bangladesh**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 438; **Burkina Faso**, 31/01/2000l U.N. Doc. A/55/38, ¶ 274; **Burundi**, 02/02/2001, U.N. Doc. A/56/38, ¶ 61; **Cameroon**, 26/06/2000, U.N. Doc. A/55/38, ¶ 59; **Colombia**, 31/05/95, U.N. Doc. A/50/38, ¶ 612; **Democratic Republic of the Congo**, 01/02/2000, U.N. Doc. A/55/38, ¶ 227; **Dominican Republic**, 14/05/98, U.N. Doc. A/53/38, ¶ 337; **Georgia**, 01/07/99, U.N. Doc. A/54/38, ¶ 111; **Guinea**, 31/07/2001, U.N. Doc. A/56/38, ¶ 128; **India**, 01/02/2000, U.N. Doc. A/55/38, ¶ 78; **Iraq**, 14/06/2000, U.N. Doc. A/55/38, ¶ 203; **Israel**, 21/07/97, U.N. Doc. A/52/38 Rev.1, Part II, ¶ 162; **Kyrgyzstan**, 27/01/99, U.N. Doc. A/54/38, ¶ 136; **Madagascar**, 12/04/94, U.N. Doc. A/49/38, ¶ 244; **Maldives**, 02/02/2001, U.N. Doc. A/56/38, ¶142; **Mongolia**, 02/02/2001, U.N. Doc. A/56/38, ¶ 273; **Morocco**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 68; **Myanmar**, 28/01/2000, U.N. Doc. A/55/38, ¶ 129; **Namibia**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 111; **Nicaragua**, 31/07/2001, U.N. Doc. A/56/38, ¶ 300; **Nigeria**, 07/07/98, U.N. Doc. A/53/38/Rev.1, ¶ 170; **Paraguay**, 09/05/96, U.N. Doc. A/51/38, ¶ 123; **Peru**, 08/07/98, U.N. Doc. A/53/38/Rev.1, ¶ 337; **Russian Federation**, 31/05/95, U.N. Doc. A/50/38, ¶ 545; **United Republic of Tanzania**, 06/07/98, U.N. Doc. A/53/38/Rev.1, ¶ 237; **Venezuela**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 236.

[99] *Id*. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.*, **Belize**, 01/07/99, U.N. Doc. A/54/38, ¶ 56; **Colombia**, 04/02/99, U.N. Doc. A/54/38, ¶ 393; **Dominican Republic**, 14/05/98, U.N. Doc. A/53/38, ¶ 337; **Madagascar**, 12/04/94, U.N. Doc. A/49/38, ¶ 244.

[100] *Id*. at 108. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.*, **Belize**, 01/07/99, U.N. Doc. A/54/38, ¶¶ 56-57; **Burundi**, 02/02/2001, U.N. Doc. A/56/38, ¶ 62; **Cameroon**, 26/06/2000, U.N. Doc. A/55/38; ¶ 60; **Colombia**, 04/02/99, U.N. Doc. A/54/38, ¶ 396; **Democratic Republic of Congo**, 01/02/2000, U.N. Doc. A/55/38, ¶ 228; **Georgia**, 01/07/99, U.N. Doc. A/54/38, ¶ 111; **Mongolia**, 02/02/2001, U.N. Doc. A/56/38, ¶ 274; **Myanmar**, 28/01/2000, U.N. Doc. A/55/38, ¶ 130; **Nicaragua**, 31/07/2001, U.N. Doc. A/56/38, ¶ 303; **Romania** 23/06/2000, U.N. Doc. A/55/38, ¶ 315; **Venezuela**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 243.

[101] *Id.* This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.*, **Burundi**, 02/02/2001, U.N. Doc. A/56/38, ¶ 62; **Iraq**, 14/06/2000, U.N. Doc. A/55/38, ¶¶ 203-204; **Nicaragua**, 31/07/2001, U.N. Doc. A/56/38, ¶ 301.

[102] *Id.* at 106. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.*, **Bangladesh**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 438; **Colombia**, 31/05/95, U.N. Doc. A/50/38, ¶ 612; **Democratic Republic of the Congo**, 01/02/2000, U.N. Doc. A/55/38, ¶ 227; **Lithuania**, 16/06/2000, U.N. Doc. A/55/38, ¶ 159; **Mexico**, 14/05/98, U.N. Doc. A/53/38, ¶ 394; **Mongolia**, 02/02/2001, U.N. Doc. A/56/38, ¶ 274; **Paraguay**, 09/05/96, U.N. Doc. A/51/38, ¶ 123; **Peru**, 08/07/98, U.N. Doc. A/53/38/Rev.1, ¶ 341; **South Africa**, 30/06/98, U.N. Doc. A/53/38/Rev.1, ¶ 134; **Ukraine**, 09/05/96, U.N. Doc. A/51/38, ¶ 287.
[103] General Recommendation 24, *supra* note 2, at para. 17.
[104] *Id.* at para. 31 (c).
[105] UNITED NATIONS DEVELOPMENT PROGRAM (UNDP), CHINA HUMAN DEVELOPMENT REPORT 2005 27 (2005).
[106] *Id.* at 58.
[107] UNITED NATIONS HEALTH PARTNERS GROUP IN CHINA, A HEALTH SITUATION ASSESSMENT OF THE PEOPLE'S REPUBLIC OF CHINA 40 (2005) [hereinafter A HEALTH SITUATION ASSESSMENT OF THE PEOPLE'S REPUBLIC OF CHINA].
[108] *Id.*
[109] *Id.*
[110] *Id.* at 45.
[111] UNDP, CHINA HUMAN DEVELOPMENT REPORT 2005, *supra* note 105, at 58.
[112] *Id.* at 78.
[113] *Id.*
[114] *Id.* at 65.
[115] *Id.* at 78.
[116] WORLD HEALTH ORGANIZATION (WHO), THE CHALLENGES OF SAFE MOTHERHOOD ISSUES AND LESSONS LEARNED 135, 137, *available at* http://www.wpro.who.int/internet/files/pub/360/135.pdf.
[117] *Id.*
[118] *Id.*; UNDP, CHINA HUMAN DEVELOPMENT REPORT 2005, *supra* note 105, at 58.
[119] WOMEN OF THE WORLD, *supra* note 14, at 43.
[120] UNDP, CHINA HUMAN DEVELOPMENT REPORT 2005, *supra* note 105, at 97.
[121] *Id.*
[122] *Id.*
[123] World Health Organization (WHO) Representative Office in China, *Maternal and child health* (July 19, 2006), *at* http://www.wpro.who.int/china/sites/mnh/overview.htm.
[124] A HEALTH SITUATION ASSESSMENT OF THE PEOPLE'S REPUBLIC OF CHINA, *supra* note 107, at 12.
[125] CHINA HUMAN DEVELOPMENT REPORT 2005, *supra* note 105, at 56.
[126] *Id.*
[127] *Id.* at 60.
[128] *Id.*
[129] *Id.*
[130] WHO, THE CHALLENGES OF SAFE MOTHERHOOD ISSUES AND LESSONS LEARNED, *supra* note 116, at 137.
[131] *Id.*
[132] Law on Maternal and Infant Health Care, *supra* note 47, at art. 5.
[133] UNDP, CHINA HUMAN DEVELOPMENT REPORT 2005, *supra* note 105, at 97.
[134] WOMEN OF THE WORLD, *supra* note 14, at 16.
[135] *Id.*
[136] WORLD HEALTH ORGANIZATION (WHO) et al., WHO/UNICEF/UNFPA ASIA REGION CONSULTATION ON MATERNAL MORTALITY ESTIMATES 8 (1998), *available at* http://www.who.int/reproductive-health/publications/mme_asia/consultation_maternal_mortality_asia.pdf.
[137] Law on Maternal and Infant Health Care, *supra* note 47, at art. 23.
[138] BRINGING RIGHTS TO BEAR, *supra* note 72, at 95. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.*, **Australia**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 400; **Austria**, 15/06/2000, U.N. Doc. A/55/38, ¶ 239; **Belarus**, 31/01/2000, U.N. Doc. A/55/38, ¶ 368; **Greece**, 01/02/99, U.N. Doc. A/54/38, ¶ 206; **Iceland**, 09/05/96, U.N. Doc.

A/51/38, ¶ 88; **Italy**, 17/09/97, U.N. Doc. A/52/38 Rev.1, Part II, ¶ 352; **Luxembourg**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 203.

[139] Stanley K. Henshaw et al., *Recent Trends in Abortion Rates Worldwide*, 25 INT'L FAMILY PLANNING PERSPECTIVES 44 (1999), *available at* http://www.guttmacher.org/pubs/journals/2504499.html.

[140] Stanley K. Henshaw et al., *The Incidence of Abortion Worldwide*, 25 INT'L FAMILY PLANNING PERSPECTIVES 30-38 (1999), *available at* http://www.guttmacher.org/pubs/journals/25s3099.html; *Report to the International Conference on Population and Development: Cairo*, U.N. Doc. A/CONF.171/13 (1994), *available at* http://www.un.org/popin/icpd/conference/offeng/poa.html.

[141] Stanley K. Henshaw et al., *The Incidence of Abortion Worldwide*, *supra* note 140.

[142] *Id.*

[143] Stanley K. Henshaw et al., *Recent Trends in Abortion Rates Worldwide*, *supra* note 139, at TABLE 1: Rates of legal induced abortion, by completeness of data and country, according to year, 1975-1996.

[144] World Health Organization (WHO) Department of Reproductive Health and Research, *Use of emergency contraceptive pills could halve the induced abortion rate in Shanghai, China*, 1 Social Science Research Policy Brief 4, (June 4, 2001) http://www.who.int/reproductive-health/hrp/Policy_briefs/pb4.pdf.

[145] Stanley K. Henshaw et al., *The Incidence of Abortion Worldwide*, *supra* note 140.

[146] Stanley K. Henshaw et al., *Recent Trends in Abortion Rates Worldwide*, *supra* note 139, at 46.

[147] Law on Maternal and Infant Health Care, *supra* note 47, at art. 19. "Termination of gestation or performance of ligation operations practiced in accordance with the provisions of this Law shall be subject to the consent and signing of the person per se. If the person per se has no capacity for civil conduct, it shall be subject to the consent and signing of the guardian of the person." Regulations on Administration of Technical Services for Family Planning, *supra* note 46, arts. 3, 14. "Citizens have the right to know and choose the contraceptive methods" and family planning institutions must obtain the consent of the patient before performing "contraceptive or birth control surgery, a special examination or a special treatment."

[148] OPEN SOCIETY INSTITUTE et al., PROMOTING HUMAN RIGHTS IN CHINA, REPORT OF THE CHINA HUMAN RIGHTS STRATEGY STUDY GROUP 4 (2001), *available at* http://www.hrichina.org/fs/downloadables/pdf/downloadable-resources/Strategy_Report_FINAL.pdf?revision_id=14242. *See* Time Magazine, *Chen Guangcheng, A Blind Man with Legal Vision* (Apr. 30, 2006), *at* http://www.time.com/time/magazine/article/0,9171,1186887,00.html. Last year, Chen Guangcheng filed a class action lawsuit on behalf of women in the Shandong province who were subjected to coercive family planning procedures by local officials. According to reports, thousands of villager women who were deemed ineligible to bear more children were forced to abort their pregnancies and forcibly sterilized. Chen Guangcheng's efforts prompted the State Family Planning Commission to call for the arrest of any local officials who conducted such practices. However, despite this assertion, only one official has been arrested. Further, Chen Guangcheng has been reported missing since April of this year. Reports speculate that he is being detained by the government.

[149] UNITED NATIONS POPULATION DIVISION, ABORTION POLICIES: A GLOBAL REVIEW (1999), *available at* http://www.un.org/esa/population/publications/abortion/doc/chinas1.doc.

[150] *Id.*

[151] WHO, *Use of emergency contraceptive pills could halve the induced abortion rate in Shanghai, China*, *supra* note 144.

[152] UNITED NATIONS POPULATION DIVISION, ABORTION POLICIES: A GLOBAL REVIEW, *supra* note 149.

[153] Duolao Wang et al., *Contraceptive Failure and Its Subsequent Effects in China: A Two-Stage Event History Analysis,* 13 ASIA-PACIFIC POPULATION J. 45 (1998), *available at* http://www.hsph.harvard.edu/grhf-asia/suchana/0310/wang_diamond_curtis.html.

[154] *Id.*

[155] BRINGING RIGHTS TO BEAR, *supra* note 72, at 105. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.,* **Antigua and Barbuda**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 258; **Bangladesh**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 438; **Belize**, 01/7/99, U.N. Doc. A/54/38, ¶¶ 56-57; **Burkina Faso**, 31/01/2000, U.N. Doc. A/55/38, ¶ 274; **Croatia**, 14/05/98, U.N. Doc. A/53/38, ¶ 109; **Cuba**, 09/05/96, U.N. Doc. A/51/38, ¶ 219; **Ethiopia**, 09/05/96, U.N. Doc. A/51/38, ¶ 160; **Georgia**, 01/07/99, U.N. Doc. A/54/38, ¶ 111; **Greece**, 01/02/99, U.N. Doc. A/54/38, ¶¶ 207-208; **Guinea**, 31/07/2001, U.N. Doc. A/56/38, ¶¶ 128-129; **Guyana**, 31/05/95, U.N. Doc. A/50/38, ¶ 621; **Hungary**, 09/05/96, U.N. Doc. A/51/38, ¶ 254; **Iraq**, 14/06/2000, U.N. Doc.

A/55/38, ¶¶ 203-204; **Kazakhstan**, 02/02/2001, U.N. Doc. A/56/38, ¶¶ 105-106; **Lithuania**, 16/06/2000, U.N. Doc. A/55/38, ¶¶ 158-159; **Mongolia**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 68; **Nicaragua**, 31/07/2001, U.N. Doc. A/56/38, ¶¶ 300-301, 303; **Nigeria**, 07/07/98, U.N. Doc. A/53/38/Rev.1, ¶¶ 170-171; **Paraguay**, 09/05/96, U.N. Doc. A/51/38, ¶ 123; **Peru**, 08/07/98, U.N. Doc. A/53/38/Rev.1, ¶¶ 337, 341; **Republic of Moldova**, 27/06/2000, U.N. Doc. A/55/38, ¶¶ 109-110; **Romania**, 23/06/2000, ¶¶ 314-315; **South Africa**, 30/06/98, U.N. Doc. A/53/38/Rev.1, ¶ 134; **Venezuela**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 236; **Vietnam**, 31/07/2001, U.N. Doc. A/56/38, ¶ 266; **Zimbabwe**, 14/05/98, U.N. Doc. A/53/38, ¶ 148.

[156] *Id.* at 105-106. *See e.g.*, **Chile**, 09/07/99, U.N. Doc. A/54/38, ¶ 227; **Greece**, 01/02/99, U.N. Doc. A/54/38, ¶¶ 207-208; **Ireland**, 01/07/99, U.N. Doc. A/54/38, ¶ 186; **Mauritius**, 31/05/95, U.N. Doc. A/50/38, ¶ 211; **Mexico**, 14/05/98, U.N. Doc. A/53/38, ¶ 394; **Nigeria**, 07/07/98, U.N. Doc. A/53/38/Rev.1, ¶ 171; **Paraguay**, 09/05/96, U.N. Doc. A/51/38, ¶123; **Peru**, 08/07/98, U.N. Doc. A/55/38/Rev.1, ¶ 341; **Venezuela**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 236; **Zimbabwe**, 14/05/98, U.N. Doc. A/53/38, ¶ 148.

[157] *Id.* at 106. *See e.g.*, **Azerbaijan**, 14/05/98, U.N. Doc. A/53/38, ¶ 73; **Belarus**, 31/01/2000, U.N. Doc. A/55/38, ¶ 374; **Burundi**, 02/02/2001, U.N. Doc. A/56/38, ¶ 62; **Cameroon**, 26/06/2000, U.N. Doc. A/55/38, ¶ 60; **Chile**, 09/07/99, U.N. Doc. A/54/38, ¶ 299; **Colombia**, 31/05/95, U.N. Doc. A/50/38, ¶ 612; **Cuba**, 09/05/96, U.N. Doc. A/51/38, ¶ 224; **Georgia**, 01/07/99, U.N. Doc. A/54/38, ¶ 112; **Greece**, 01/02/99, U.N. Doc. A/54/38, ¶ 208; **Guinea**, 31/07/2001, U.N. Doc. A/56/38, ¶ 129; **Ireland**, 01/07/99, U.N. Doc. A/54/38, ¶ 186; **Kazakhstan**, 02/02/2001, U.N. Doc. A/56/38, ¶ 106; **Kyrgyzstan**, 27/01/99, U.N. Doc. A/54/38, ¶ 137; **Mongolia**, 02/02/2001, U.N. Doc. A/56/38, ¶ 274; **Myanmar**, 28/01/2000, U.N. Doc. A/55/38, ¶ 130; **Nepal**, 01/07/99, U.N. Doc. A/54/38, ¶ 148; **Nicaragua**, 31/07/2001, U.N. Doc. A/56/38, ¶ 303; **Nigeria**, 07/07/98, U.N. Doc. A/53/38/Rev.1, ¶ 171; **Paraguay**, 09/05/96, U.N. Doc. A/51/38, ¶ 123; **Peru**, 08/07/98, U.N. Doc. A/53/38/Rev.1, ¶ 342; **Philippines**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 301; **Republic of Moldova**, 27/06/2000, U.N. Doc. A/56/38, ¶ 110; **Romania**, 23/06/2000, U.N. Doc. A/55/38, ¶ 315; **Saint Vincent and the Grenadines**, 12/08/97, U.N. Doc. A/52/38/Reev.1, ¶ 147; **Slovakia**, 30/06/98, U.N. Doc. A/53/38/Rev.1, ¶ 92; **Slovenia**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 119; **South Africa**, 30/06/98. U.N. Doc. A/53/38/Rev.1, ¶ 134; **Uzbekistan**, 02/02/2001, U.N. Doc. A/56/38, ¶ 186; **Venezuela**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 236; **Vietnam**, 31/07/2001, U.N. Doc. A/56/38, ¶ 267.

[158] *Id.* at 107. *See e.g.*, **Antigua and Barbuda**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 267; **Burundi**, 02/02/2001, U.N. Doc. A/56/38, ¶ 62; **Colombia**, 04/02/99, U.N. Doc. A/54/38, ¶ 396; **Czech Republic**, 14/05/98, U.N. Doc. A/53/38, ¶ 205; **Finland**, 31/05/95, U.N. Doc. A/50/38, ¶ 390; **Jamaica**, 02/02/2001, U.N. Doc. A/56/38, ¶ 224; **Nicaragua**, 31/07/2001, U.N. Doc. A/56/38, ¶ 303; **Saint Vincent and the Grenadines**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 147; **Slovakia**, 30/06/98, U.N. Doc. A/53/38/Rev.1, ¶ 92; **Slovenia**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 119; **Uganda**, 31/05/95, U.N. Doc. A/50/38, ¶ 338; **Zimbabwe**, 14/05/98, U.N. Doc. A/53/38, ¶¶ 160-161.

[159] Xu Qian et al., *Unintended Pregnancy and Induced Abortion among Unmarried Women in China: A Systematic Review,* 4 BMC HEALTH SERVICES RESEARCH (2004).

[160] Bo Wang et al., *The Potential of Comprehensive Sex Education in China: Findings from Suburban Shanghai*, 31 INT'L FAMILY PLANNING PERSPECTIVES 63 (2005), *available at* http://www.guttmacher.org/pubs/journals/3106305.html.

[161] *Id.* at 63, 70.

[162] *Id.* at 64.

[163] *Id.* at 69.

[164] *Id.* at 70.

[165] BRINGING RIGHTS TO BEAR, *supra* note 72, at 160. *See e.g.*, **Antigua and Barbuda**, 12/08/97, U.N. Doc. A/52/38.Rev.1, Part II, ¶ 261; **Belize**, 01/07/99, U.N. Doc. A/54/38, ¶¶ 39, 58; **Burundi**, 02/02/2001, U.N. Doc. A/56/38, ¶ 59, **Guinea**, 31/07/2001, U.N. Doc. A/56/38, ¶ 130, 136-137; **Guyana**, 31/07/2001, U.N. Doc. A/56/38, ¶¶ 151, 178; **Myanmar**, 28/01/2000, U.N. Doc. A/55/38, ¶ 95, 121; **Namibia**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 79; **Romania**, 23/06/2000, U.N. Doc. A/55/38, ¶ 314; **United Kingdom of Great Britain and Northern Ireland**, 01/07/99, U.N. Doc. A/54/38, ¶ 309; **Vietnam**, 31/07/2001, U.N. Doc. A/56/38, ¶ 266.

[166] *Id. See e.g.,* **Egypt**, 02/02/2001, U.N. Doc. A/56/38, ¶¶ 336-337.

[167] *Id. See e.g.,* **Guyana**, 31/07/2001, U.N. Doc. A/56/38, ¶ 179; **Ethiopia**, 09/05/96, U.N. Doc. A/51/38, ¶ 161; **Peru**, 08/07/98, U.N. Doc. A/55/38/Rev.1, ¶ 343; **Myanmar**, 28/01/2000, U.N. Doc. A/55/38, ¶ 96; **Uganda**, 31/05/95, U.N. Doc. A/50/38, ¶ 338.
[168] *Id. See e.g.,* **Belize**, 01/07/99, U.N. Doc. A/54/38, ¶ 59; **Burkina Faso**, 31/01/2000, U.N. Doc. A/55/38, ¶ 276; **Burundi**, 02/02/2001, U.N. Doc. A/56/38, ¶ 60; **Cameroon**, 26/06/2000, U.N. Doc. A/55/38, ¶ 60; **Colombia**, 04/02/99, U.N. Doc. A/54/38, ¶ 346; **Cuba**, 09/05/96, U.N. Doc. A/51/38, ¶ 224; **Dominican Republic**, 14/05/98, U.N. Doc. A/55/38, ¶ 349; **Guyana**, 31/07/2001, U.N. Doc. A/56/38, ¶ 179; **Iraq**, 14/06/2000, U.N. Doc. A/55/38, ¶ 203; **Myanmar**, 28/01/2000, U.N. Doc. A/55/38, ¶ 96; **Uganda**, 31/05/95, U.N. Doc. A/50/38, ¶ 320; **United Republic of Tanzania**, 06/07/98, U.N. Doc. A/53/38/Rev.1, ¶ 214; **Vietnam**, 31/07/2001, U.N. Doc. A/56/38, ¶ 267.
[169] *Id. See e.g.,* **Myanmar**, 28/01/2000, U.N. Doc. A/55/38, ¶ 96; **Uganda**, 31/05/95, U.N. Doc. A/50/38, ¶ 338; **United Kingdom of Great Britain and Northern Ireland**, 01/07/99, U.N. Doc. A/54/38, ¶ 310; **Vietnam**, 31/07/2001, U.N. Doc. A/56/38, ¶ 267; **Zimbabwe**, 14/05/98, U.N. Doc. A/53/38, ¶ 160.
[170] *Id. See e.g.,* **Belize**, 01/07/99, U.N. Doc. A/54/38, ¶ 59; **Burundi**, 02/02/2001, U.N. Doc. A/56/38, ¶ 60; **Guinea**, 31/07/2001, U.N. Doc. A/56/38, ¶ 131; **Uganda**, 31/05/95, U.N. Doc. A/50/38, ¶ 313; **Vietnam**, 31/07/2001, U.N. Doc. A/56/38, ¶ 267.
[171] *Id. See e.g.,* **Burundi**, 02/02/2001, U.N. Doc. A/56/38, ¶ 59.
[172] *Id. See e.g.,* **Guinea**, 31/07/2001, U.N. Doc. A/56/38, ¶ 130.
[173] *Id. See e.g.,* **Romania**, 23/06/2000, U.N. Doc. A/55/38, ¶ 315.
[174] *Id. See e.g.,* **Cuba**, 09/05/96, U.N. Doc. A/51/38, ¶ 224; **Guyana**, 31/07/2001, U.N. Doc. A/56/38, ¶ 178; **United Kingdom of Great Britain and Northern Ireland**, 01/07/99, U.N. Doc. A/54/38, ¶ 309; **Zimbabwe**, 14/05/98, U.N. Doc. A/53/38, ¶ 147.
[175] *Id.* at 161. *See e.g.,* **India**, 01/02/2000, U.N. Doc. A/55/38, ¶ 76; **Myanmar**, 28/01/2000, U.N. Doc. A/55/38, ¶ 122; **Peru**, 08/07/98, U.N. Doc. A/55/38/Rev.1, ¶¶ 325-326.
[176] *Id. See e.g.,* **Bolivia**, 31/05/95, U.N. Doc. A/50/38, ¶ 65; **Guinea**, 31/07/2001, U.N. Doc. A/56/38, ¶ 136; **Guyana**, 31/0/7/2001, U.N. Doc. A/56/38, ¶ 181; **India**, 01/02/2000, U.N. Doc. A/55/38, ¶ 76; **Myanmar**, 28/01/2000, U.N. Doc. A/55/38, ¶ 122; **Nigeria**, 07/07/98, U.N. Doc. A/53/38/Rev.1, ¶ 168; **Peru**, 08/07/98, U.N. Doc. A/55/38/Rev.1, ¶¶ 325-326.
[177] *Id. See e.g.,* **Armenia**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 59; **Cameroon**, 26/06/2000, U.N. Doc. A/55/38, ¶ 52; **China**, 03/02/99, U.N. Doc. A/54/38, ¶ 289; **Cuba**, 09/05/96, U.N. Doc. A/51/38, ¶ 224; **Democratic Republic of the Congo**, 01/02/2000, U.N. Doc. A/55/38, ¶ 220; **Guinea**, 31/07/2001, U.N. Doc. A/56/38, ¶ 137; **Guyana**, 31/07/2001, U.N. Doc. A/56/38, ¶ 181; **Myanmar**, 28/01/2000, U.N. Doc. A/55/38, ¶ 122; **Tunisia,** 31/05/95, U.N. Doc. A/50/38, ¶ 229; **Uganda**, 31/05/95, U.N. Doc. A/50/38, ¶ 318.
[178] *Concluding Observations of the Committee on the Rights of the Child (CRC): China*, *supra* note 61, at paras. 32, 69, 70.
[179] WORLD HEALTH ORGANIZATION (WHO), HIV/AIDS IN ASIA AND THE PACIFIC REGION 2003, 9, *available at* http://www.wpro.who.int/NR/rdonlyres/11ED3283-9821-43BE-9B73-B3444A3DADE6/0/HIV_AIDS_Asia_Pacific_Region2003.pdf.
[180] WOMEN OF THE WORLD, *supra* note 14, at 46.
[181] WHO, HIV/AIDS IN ASIA AND THE PACIFIC REGION 2003, *supra* note 179, at 11, TABLE 2: Estimated HIV Prevalence and Major Mode(s) of HIV Transmission in Asia-Pacific Countries (2002).
[182] WHO, Summary Country Profile for HIV/AIDS Treatment Scale-up June, 2005. *available at* http://www.who.int/3by5/support/june2005_chn.pdf.
[183] *Id.*
[184] UNICEF, HIV/AIDS: Issue, *available at* http://www.unicef.org/china/hiv_aids.html
[185] WOMEN OF THE WORLD, *supra* note 14, at 46.
[186] WHO, HIV/AIDS IN ASIA AND THE PACIFIC REGION 2003, *supra* note 179, at 21.
[187] *Id.* at 50.
[188] WHO, Summary Country Profile for HIV/AIDS Treatment Scale-up 2005, *supra* note 182.
[189] *Id.*; WOMEN OF THE WORLD, *supra* note 14, at 46.
[190] WOMEN OF THE WORLD, *supra* note 14, at 47.
[191] WHO, Summary Country Profile for HIV/AIDS Treatment Scale-up 2005, *supra* note 182.

[192] WHO, HIV/AIDS IN ASIA AND THE PACIFIC REGION 2003, *supra* note 179, at 3, 9. HIV transmission associated with HIV-contaminated plasma collection equipment was the cause of a large number of infections from the early 1990s to the mid-1990s, at which time it was recognized. *Id.*
[193] *Id.* at 9, 13; WHO, Summary Country Profile for HIV/AIDS Treatment Scale-up 2005, *supra* note 182.
[194] WHO, HIV/AIDS IN ASIA AND THE PACIFIC REGION 2003, *supra* note 179, at 53.
[195] *Id.* at 21.
[196] *Id.* at 52.
[197] *Id.* at 21.
[198] *Id.* at 89, Annex 2: Prevention of mother-to-child transmission.
[199] WOMEN OF THE WORLD, *supra* note 14, at 47.
[200] UNICEF, HIV/AIDS: Issue, *supra* note 184.
[201] WOMEN OF THE WORLD, *supra* note 14, at 47.
[202] WHO, HIV/AIDS IN ASIA AND THE PACIFIC REGION 2003, *supra* note 179, at 52.
[203] World Health Organization (WHO) Department of Reproductive Health and Research, *Improved services and counseling reduce risk-taking behaviour and increase condom use in Shanghai, China*, 1 Social Science Research Policy Brief 3, (June 2000) *at* http://www.who.int/reproductive-health/hrp/Policy_briefs/pb3.pdf [hereinafter WHO, *Improved services and counseling reduce risk-taking behaviour and increase condom use in Shanghai, China*].
[204] *Id.*
[205] *Id.*
[206] *Id.*
[207] WHO, Summary Country Profile for HIV/AIDS Treatment Scale-up 2005, *supra* note 182.
[208] *Id.*
[209] UNICEF, HIV/AIDS: Issue, *supra* note 184.
[210] WHO, Summary Country Profile for HIV/AIDS Treatment Scale-up 2005, *supra* note 182.
[211] *Id.*
[212] *Id.*
[213] *Id.*
[214] *Id.*
[215] *Id.*
[216] *Id.*
[217] *Id.*
[218] *Id.*
[219] UNICEF, HIV/AIDS: Issue, *supra* note 184.
[220] WHO, HIV/AIDS IN ASIA AND THE PACIFIC REGION 2003, *supra* note 179, at 50.
[221] *Id.* at 52.
[222] Marwaan Macan-Markar, *HEALTH-ASIA: "Interest in Combating HIV/AIDS Flagging,"* (July 18, 2006), INTER PRESS SERVICE NEWS AGENCY, *available at* http://www.ipsnews.net/news.asp?idnews=34002.
[223] WHO, HIV/AIDS IN ASIA AND THE PACIFIC REGION 2003, *supra* note 179, at 52; WHO, Improved services and counseling reduce risk-taking behaviour and increase condom use in Shanghai, China, *supra* note 203.
[224] UNICEF, HIV/AIDS: Issue, *supra* note 184.
[225] WHO, *Improved services and counseling reduce risk-taking behaviour and increase condom use in Shanghai, China*, *supra* note 203, at 3.
[226] *Id.*
[227] *Id.* at 6.
[228] WOMEN OF THE WORLD, *supra* note 14, at 49.
[229] WHO, Summary Country Profile for HIV/AIDS Treatment Scale-up 2005, *supra* note 182.
[230] World Health Organization (WHO) Department of Reproductive Health and Research, *Young female migrant workers in China in need of reproductive health information and services*, 2 Social Science Research Policy Brief 2, (May 2002) *at* http://www.who.int/reproductive-health/hrp/Policy_briefs/pb5.pdf [hereinafter WHO, *Young female migrant workers in China in need of reproductive health information and services*].
[231] *Id.*

[232] *Id.*
[233] United Nations International Children's Emergency Fund (UNICEF) China, Protection and Community Services: Migrant children, (last visited July 7, 2006) *at* http://www.unicef.org/china/protection_community_487.html.
[234] WHO, *Young female migrant workers in China in need of reproductive health information and services*, *supra* note 230.
[235] *Id.*
[236] *Id.*
[237] *Id.*
[238] *Id.*
[239] *Id.*
[240] *Id.*
[241] *Id.*