

China's One-Child Family Policy

TO THE EDITOR: Hesketh and colleagues (Sept. 15 issue)¹ provide an interesting survey of the effects of the infamous Chinese one-child policy after 25 years. However, I was somewhat taken aback by the authors' editorial statement that "relaxation of the policy can be considered only if fertility aspirations are such that a baby boom will not result." Certainly, this is the same sort of argument that tyrannical regimes have given for continuing their oppressive policies, from apartheid and dictatorships to the oppression of women and just about any other human-rights violation through history. The policy of one child per family has been a terrible violation of the personal rights of millions of Chinese women. All that is necessary for the draconian policy to be removed, not just "relaxed," is for the Chinese government to make the decision to stop such repressive measures and start dealing with the problems posed by an expanding population through moral means. I am disappointed to see the "ends justify the means" logic endorsed and unchallenged on the pages of a respectable medical journal.

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1. Hesketh T, Lu L, Xing ZW. The effect of China's one-child family policy after 25 years. *N Engl J Med* 2005;353:1171-6.

THE AUTHORS REPLY: We agree that the one-child policy is a violation of the human right to reproductive choice, as we acknowledge in our article. It is precisely for this reason that it is so controversial. But we should not judge the Chinese by Western standards. Few Chinese see the policy as a human-rights violation. Most (though not all) accept it with equanimity, even in the cities where the one-child rule is enforced. This is perhaps less surprising when one considers the overcrowding in Chinese cities, the pressures of child care with two working parents (as is usually the case), and the high cost of raising children.

The Chinese authorities would argue that the policy has contributed to improvements in human rights by lifting more than 200 million people out of poverty and by raising living standards for the majority of the population. In an increasingly interdependent world, where available natural resources per capita are decreasing, the Chinese government should perhaps be applauded for having the courage to take unpopular measures to control population growth.

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Public Health Principles for the HIV Epidemic

TO THE EDITOR: We commend the call by Frieden et al. (Dec. 1 issue)¹ for a comprehensive public health approach to the epidemic of human immunodeficiency virus (HIV) infection. The authors' lack of evidence with regard to the relative impact of their case-finding approach, however, raises questions about the scientific basis for their conclusions. Given that there is considerable stigma against injection-drug users, men who have sex with men, and sex workers in many localities and institutions, it is important to evaluate whether the case-finding techniques would increase stigmatization of those at risk and thereby weaken HIV-prevention efforts among stigmatized and fearful risk groups. Injection-drug users in New York City began reducing their high-risk behavior before AIDS was identified in 1981, and their effec-

tive efforts to minimize risk and to communicate methods of risk reduction still continue.²⁻⁴ Organizing on the part of homosexual men since the early days of the HIV epidemic has contributed to far-reaching effects on policy, high-risk behavior, and community norms.⁵ Before the case-finding proposals of Frieden and colleagues are implemented, research should determine whether they would weaken the prevention efforts of the populations at risk.

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2. Friedman SR, Curtis R, Neaigus A, Jose B, Des Jarlais DC. Social networks, drug injectors' lives, and HIV/AIDS. New York: Kluwer Academic, 1999.
3. Friedman SR, Maslow C, Bolyard M, Sandoval M, Mateu-Gelabert P, Neaigus A. Urging others to be healthy: "intra-vention" by injection drug users as a community prevention goal. *AIDS Educ Prev* 2004;16:250-63.
4. Des Jarlais DC, Perlis T, Arasteh K, et al. "Informed altruism" and "partner restriction" in the reduction of HIV infection in injecting drug users entering detoxification treatment in New York City, 1990-2001. *J Acquir Immune Defic Syndr* 2004;35:158-66.
5. Kippax S, Race K. Sustaining safe practice: twenty years on. *Soc Sci Med* 2003;57:1-12.

TO THE EDITOR: Hurray for Frieden et al. for clearly elucidating the need for applying public health principles to the HIV epidemic. As the authors point out, routine HIV testing as part of primary care is indicated on the basis of clinical efficacy and cost-effectiveness.¹⁻³ Routine HIV testing is now recommended for all pregnant women as part of their prenatal care, irrespective of perceived risk.⁴ Written informed consent is a barrier to the implementation of these recommendations. Although written informed consent was necessary in the past, improved knowledge of HIV and AIDS and current legal protections make such consent unnecessary and burdensome in most settings. Although HIV testing should be routine in a myriad of settings, it should not be mandatory or coerced. Oral informed consent for HIV testing (as is standard for testing for other sexually transmitted diseases) is appropriate. States should consider changing HIV-related regulations to do away with mandatory written informed consent.

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1. Sanders GD, Bayoumi AM, Sundaram V, et al. Cost-effectiveness of screening for HIV in the era of highly active antiretroviral therapy. *N Engl J Med* 2005;352:570-85.
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THE AUTHORS REPLY: Increased detection of HIV infection benefits infected persons, their contacts, and the community. When HIV infection is diagnosed before the onset of clinical illness, patients can decide when to start treatment and can avoid serious complications. Patients who receive a diagnosis late in their illness are much more likely to die within a year of diagnosis¹; those who know they are infected reduce risky behavior by about half.²

There is no evidence that a standard offer of voluntary HIV testing as part of normal medical care will increase stigma. Indeed, persons may well encounter reduced discrimination if voluntary testing is offered universally in health care settings.

The stigma of an HIV diagnosis can be devastating, but the alternative — not getting care, spreading infection to others, continuing to encounter stigma, and dying prematurely of AIDS — is even worse. A generation ago, cancer was stigmatized; it is now markedly less so owing to increased identification of cases, improved treatment, and public education. We concur with Friedman and Sherman that more research and action are needed to mitigate the serious problem of HIV-related stigma.

We agree with Flanigan et al. that written consent for HIV testing now represents a major and unnecessary barrier to helping patients voluntarily learn their HIV status. State laws requiring written consent separate from the general consent for medical diagnosis and treatment should be changed.

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