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L. M. Cirando

Abstract

This Note argues that, in light of the views emphasized at the Cairo Conference, the population policies of China and the United States violate women's rights by denying women the opportunity to make voluntary choices regarding child-bearing and fertility regulation. Part I discusses the involvement of the United Nations with population policy-making and summarizes two U.N.-sponsored international population policy action plans. Part II presents the population policies of China and the United States, examines their rationales for implementation, and explains how the policies affect women's reproductive choices. Part III argues that the population policies of China and the United States violate women's right to informed choice and offers an alternate policy solution that provides for controlled population growth with full respect for women's right to informed choice.

NOTES

INFORMED CHOICE AND POPULATION POLICY: DO THE POPULATION POLICIES OF CHINA AND THE UNITED STATES RESPECT AND ENSURE WOMEN'S RIGHT TO INFORMED CHOICE?

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INTRODUCTION

Rapid and uncontrolled population growth¹ threatens wide-spread famine,² frustrates economic development,³ strains social

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1. *Report of the International Conference on Population and Development*, Annex at 5, 14-17, U.N. Doc. A/Conf.171/13 (1994) [hereinafter *Cairo Programme*].

The growth of the world population is at an all-time high in absolute numbers, with current increments approaching 90 million persons annually. According to United Nations projections, annual population increments are likely to remain close to 90 million until the year 2015. While it had taken 123 years for world population to increase from 1 billion to 2 billion, succeeding increments of 1 billion took 33 years, 14 years and 13 years. The transition from the fifth to the sixth billion, currently under way, is expected to take only 11 years and to be completed by 1998.

Id. at 35. In addition, recent population projections indicate that world population may grow by four billion in thirty years, reaching 9.4 billion by the year 2025. *Report of the Secretary-General of the Conference: Synthesis of the Expert Group Meetings convened as part of the substantive preparations for the Conference*, U.N. Preparatory Committee for the International Conference on Population and Development, 2d Sess., Prov. Agenda Item 4, at 10, U.N. Doc. E/Conf.84/PC/12 (1993) [hereinafter *Expert Synthesis*].

2. See, e.g., *Report of the Secretary-General: Fourth review and appraisal of the World Population Plan of Action*, U.N. Preparatory Committee for the International Conference on Population and Development, 3d Sess., Prov. Agenda Item 4, at 12-13, U.N. Doc. A/Conf.171/PC/3 (1994) [hereinafter *Fourth review*] (reporting that "800 million people still do not get sufficient food" even though growth of food production has kept pace with population increases); PAUL R. EHRLICH, *THE POPULATION BOMB* 3-4, 18-25 (2d ed. 1968) (suggesting that uncontrolled population growth leads to famine and death); T.R. MALTHUS, *AN ESSAY ON POPULATION* 8-11 (J.M. Dent & Sons Ltd. 1960) (1798) (proposing that because population increases geometrically while food supplies increase only arithmetically, food supplies will be depleted unless steps are taken to curb population growth).

3. See, e.g., *Cairo Programme*, *supra* note 1, at 20-21 (finding nexus between poverty and rapid population growth); *Expert Synthesis*, *supra* note 1, at 4-5 (noting connection between poverty and rapid population growth). Today, more than one billion people around the globe live in absolute poverty. *Report of the Secretary-General of the Conference: Recommendations of the Expert Group Meeting on Population, Environment and Development*,

resources,⁴ and portends ecological disaster.⁵ The Programme

U.N. Pop. Comm. Acting as the Preparatory Committee for the International Conference on Population and Development, 2d Sess., Prov. Agenda Item 3, at 5, U.N. Doc. E./Conf.84/PC/4 (1992) [hereinafter *Population, Environment and Development*]. The Cairo Programme recognizes that:

Poverty is often accompanied by unemployment, malnutrition, illiteracy, low status of women, exposure to environmental risks and limited access to social and health services, including reproductive health services which, in turn, include family planning. All these factors contribute to high levels of fertility, morbidity and mortality, as well as to low economic productivity. . . . Eradication of poverty will contribute to slowing population growth and to achieving early population stabilization.

Id. at 20. The twentieth century view, that population growth threatens economic development, contrasts with the seventeenth and eighteenth century European mercantilist view that large populations were advantageous and with the European Utopian view that modern science and social reform could accommodate any size population. See RUTH DIXON-MUELLER, *POPULATION POLICY & WOMEN'S RIGHTS: TRANSFORMING REPRODUCTIVE CHOICE* 4 (1993) (summarizing history of thought regarding economic and population growth leading to twentieth century movement for population control).

4. See, e.g., *Cairo Programme*, *supra* note 1, at 33, 44, 55-56 (discussing effects of rapid population growth on quality of health care services, education, and socio-economic supports for families). "Conditions have worsened for many families in recent years, owing to the lack of gainful employment and measures taken by Governments seeking to balance their budget by reducing social expenditures." *Id.* at 33. "The impact of reductions in expenditures for health and other social services which have taken place in many countries as a result of public-sector retrenchment, misallocation of available health resources, structural adjustment and the transition to market economies . . . is also a factor in increasing morbidity and mortality." *Id.* at 55; see *Population, Environment and Development*, *supra* note 3, at 5 (noting continued underemphasis in both national and international development programs on health care services, family planning, housing, and education).

5. See, e.g., *Cairo Programme*, *supra* note 1, at 18, 22-24 (noting that "unsustainable consumption and production patterns are contributing to the unsustainable use of natural resources and environmental degradation"); *Expert Synthesis*, *supra* note 1, at 4-5 (noting adverse impacts of rapid population growth on availability of natural resources); *Population, Environment and Development*, *supra* note 3, at 6-16 (discussing adverse impacts of population growth on environment, including destruction of tropical forests, scarcity of freshwater resources, loss of biological diversity, and climate change); EHRLICH, *supra* note 2, at 26-44 (concluding that overpopulation leads to environmental deterioration). The theory that population growth damages the environment recognizes that an increase in population adds to the number of consumers who produce pollution and place additional stresses on natural resources. *Population, Environment and Development*, *supra* note 3, at 6. Nations of the southern hemisphere, however, challenge the view that population growth is the primary cause of environmental degradation. DIXON-MUELLER, *supra* note 3, at 77-78. These nations argue that to place the blame for environmental deterioration on population growth oversimplifies the complex relationships between population, development, and the environment. *Id.* Instead, these nations argue that waste and overconsumption in northern hemisphere countries constitute a leading cause of environmental deterioration. *Id.* The Cairo Programme acknowledges both sides of the debate: "Demographic factors, combined with poverty and lack of access to resources in some areas, and excessive consumption

of Action⁶ ("Cairo Programme" or "Programme") of the 1994 International Conference on Population and Development⁷ ("ICPD" or "Cairo Conference") offers solutions to population-related problems and, through its recognition of informed choice,⁸ proposes limits on states' population policies.⁹ China

and wasteful production patterns in others, cause or exacerbate problems of environmental degradation and resource depletion and thus inhibit sustainable development." *Cairo Programme*, *supra* note 1, at 23.

6. *Cairo Programme*, *supra* note 1, at 5-118. As the final document of the International Conference on Population and Development ("ICPD" or "Cairo Conference"), the Programme of Action ("Cairo Programme" or "Programme") outlines a novel plan of action for stabilizing population growth through improvements in the status of women. *Id.* at 11; see Barbara B. Crane & Stephen L. Isaacs, *The Cairo Programme of Action: A New Framework for International Cooperation on Population and Development Issues*, 36 HARV. INT'L L.J. 295, 296 (1995) (noting that "[f]or the first time, the needs and perspectives of women took center stage in the population debate at the international level"). "Its about health, empowerment and rights and not about the old-fashioned way of population control. Past approaches . . . have not sought to change the political and social standing of women." Julia Preston, *U.N. Report: To Stem Population, Empower Women*, WASH. POST, Aug. 18, 1994, at A24 (quoting Adrienne Germain, Vice President, International Women's Health Coalition).

Perhaps the most distinctive element of the [Cairo Programme] is its emphasis on improving the rights, opportunities and economic status of girls and women. . . . [O]ne of the most effective ways of bringing down the number of unwanted pregnancies and increasing the use of modern contraceptives is to improve the lot of girls and women.

Boyce Rensberger, *As Birthrates Fall, Population Rises*, WASH. POST, Sept. 4, 1994, at A1. Despite controversy, especially regarding the Programme's language on abortion, sexuality, and reproductive and sexual health, the Cairo Conference adopted the Cairo Programme on September 13, 1994. *Id.*; see Crane & Isaacs, *supra*, at 299-300 (discussing debate among women's coalitions, population specialists, and Roman Catholic and Islamic fundamentalists). Chapter VII of the Programme, the chapter on reproductive health, reproductive rights, and family planning, received the most reservations. *Cairo Programme*, *supra* note 1, at 135-51 (outlining reservations to Chapter VII by representatives of: Libyan Arab Jamahiriya; Yemen; Egypt; Indonesia; Algeria; Afghanistan; Syrian Arab Republic; El Salvador; Kuwait; Jordan; Malta; Islamic Republic of Iran; Malaysia; Djibouti and Maldives; Brunei Darussalam; Honduras; Nicaragua; Paraguay; Argentina; Ecuador; Guatemala; and the Holy See). In December 1994, the General Assembly endorsed the Cairo Programme and urged governments to commit themselves at the highest political levels to implement the Cairo Programme. G.A. Res. 49/128, U.N. GAOR, 49th Sess., Agenda Item 158, U.N. Doc. A/RES/49/128 (1995).

7. *Report of the International Conference on Population and Development*, at 120, U.N. Doc. A/Conf.171/13 (1994) [hereinafter *Cairo Attendance Report*]. Approximately 180 countries attended ICPD, which was held in Cairo, Egypt from September 5 to September 13, 1994. *Id.* at 120-22.

8. *Cairo Programme*, *supra* note 1, at 43-49. The Cairo Programme discusses informed choice within the context of reproductive health, reproductive rights, and family planning. *Id.* Informed choice is an essential element of women's reproductive rights and is vital to the achievement of optimum health. *Id.*; DECLARATION ON ETHICAL PRINCIPLES, ROUNDTABLE ON ETHICS, POPULATION AND REPRODUCTIVE HEALTH (United

and the United States¹⁰ adopted population policies to address the effects of rapid population growth on their plans for socio-economic development.¹¹ As participants in the ICPD, China

Nations Population Fund & The Development Law & Policy Program of Columbia University's Center for Population and Family Health, New York, N.Y.), Mar. 8-10, 1994, at 6 [hereinafter *DECLARATION*]. The elements of informed choice are best understood by reference to the doctrine of informed consent. *DECLARATION, supra*, at 6.

The doctrine of informed consent is an embodiment of respect for persons. A fuller expression of this principle expands the concept of informed consent to that of informed choice, which requires that individuals be given a range of alternatives and the right to refuse unwanted family planning methods or medical procedures.

Id. While the Programme does not define informed choice explicitly, it emphasizes that states "should use the full means at their disposal to support the principle of voluntary choice in family planning." *Id.* at 47. Moreover, the Cairo Programme urges "Governments [to] secure conformity to human rights and to ethical and professional standards in the delivery of family planning and related reproductive health services aimed at ensuring responsible, voluntary and informed consent." *Id.*

9. See STEPHEN L. ISAACS & ANDREA IRVIN, *POPULATION POLICY: A MANUAL FOR POLICYMAKERS AND PLANNERS* 4 (2d ed. 1991) [hereinafter *POPULATION POLICY MANUAL*] (defining term "population policy"). A population policy represents the means by which a government seeks to affect population size, distribution, or composition. *Fourth review, supra* note 2, at 9; DIXON-MUELLER, *supra* note 3, at 5. More specifically, population policies form the "constituent elements of socio-economic development policies whose aim is to affect, *inter alia*, population growth, morbidity and mortality, reproduction and family formation, population distribution and internal migration, international migration and, consequently, demographic structures." *Fourth review, supra* note 2, at 9. Population policies can be grouped into four categories: (1) reproductive policies that seek to raise or lower the overall birth rate in order to affect population size; (2) health policies that seek to reduce mortality and morbidity; (3) migration and urbanization policies that seek to affect the spatial distribution of the population; and (4) family and welfare policies that have significant effects on reproductive behavior. DIXON-MUELLER, *supra* note 3, at 15-16. The primary goals of population policy are to improve the quality of life and enhance human dignity. *Cairo Programme, supra* note 1, at 14-17. Population policies may be explicit or implicit. *POPULATION POLICY MANUAL, supra*, at 4-5. Explicit population policies announce publicly a government's intention to affect population size, distribution, or composition. *Id.* Implicit population policies affect population size, distribution, or composition even though these may not be the stated purpose. *Id.* at 4.

10. *WORLD ALMANAC AND BOOK OF FACTS* 839 (Robert Famighetti et al. eds., 1995). China is the most populous nation in the world, with more than one-fifth of the world's population, or a total population of over 1.2 billion. *Id.* The United States is the third largest with over 260 million people. *Id.*

11. See H. YUAN TIEN, *CHINA'S STRATEGIC DEMOGRAPHIC INITIATIVE* 116-21 (1991) [hereinafter "*CHINA'S SDI*"] (discussing development of China's One-Child Family Policy). China adopted a population policy limiting families to one child because it concluded that high birth rates frustrated its plans for modernization and economic development. *Id.* at 22, 86. In the United States, Aid to Families with Dependent Children ("AFDC") functions as an implicit population policy to the extent that AFDC legislation attempts to affect the reproductive behavior of AFDC recipients. See, e.g., Lucy A. Williams, *The Ideology of Division: Behavior Modification Welfare Reform Proposals*, 102 *YALE*

and the United States pledged to ensure that their population policies respect women's right to informed choice.¹²

This Note argues that, in light of the views emphasized at the Cairo Conference, the population policies of China and the United States violate women's rights by denying women the opportunity to make voluntary choices regarding child-bearing and fertility regulation.¹³ Part I discusses the involvement of the United Nations with population policy-making and summarizes two U.N.-sponsored international population policy action plans. Part I also defines informed choice by reference to specific elements of the doctrine of informed consent. Part II presents the population policies of China and the United States, examines their rationales for implementation, and explains how the policies affect women's reproductive choices. Part III argues that the population policies of China and the United States violate women's right to informed choice and offers an alternate policy solution that provides for controlled population growth with full respect for women's right to informed choice. This Note concludes that unless China and the United States implement the suggested policy alternative, women living in China and the United States will be denied the full dignity of their human rights.

I. *POPULATION POLICYMAKING AND INFORMED CONSENT*

The United Nations¹⁴ ("U.N.") became involved with popu-

L.J. 719 (1992) (discussing how AFDC acts as tool for behavior modification). Today, a majority of the U.S. Congress advocates AFDC reform because, in their view, AFDC encourages illegitimacy, teen pregnancy, and contributes to the impoverishment of America. Work Opportunity Act of 1995, H.R. 4, 104th Cong., 1st Sess. § 101 (1995) [hereinafter WOA] (Senate version); Personal Responsibility Act of 1995, H.R. 4, 104th Cong., 1st Sess. § 101 (1995) [hereinafter PRA] (House version). Both of the proposed Congressional reform bills include punitive measures designed to deter childbearing among AFDC recipients. WOA, H.R. 4, 104th Cong., 1st Sess. § 101(b) (1995) (proposed codification at 42 U.S.C. §§ 406 (b)-(d)); PRA, H.R. 4, 104th Cong., 1st Sess. § 101 (1995) (proposed codification at 42 U.S.C. §§ 405 (a)(4)-(5)).

12. *Cairo Programme*, *supra* note 1, at 43-49; *Cairo Attendance Report*, *supra* note 7, at 120, 122.

13. *See supra* note 8 and accompanying text (defining informed choice to include requirement that states respect and ensure women's rights to make voluntary reproductive choices).

14. U.N. CHARTER art. 55. The United Nations derives its authority to address population policy issues from Article 55 of its Charter, which provides that:

[T]he United Nations shall promote:

lation policy-making with the creation of the Population Commission¹⁵ in 1946.¹⁶ Since that time, the United Nations has sponsored five international population conferences.¹⁷ In 1994, attendees at the approved an action plan for population policy-

-
- a. higher standards of living, full employment, and conditions of economic and social progress and development;
 - b. solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and
 - c. universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.

Id. The United Nations may make recommendations on any matter falling within the scope of its Charter. *Id.* The General Assembly and the Economic and Social Council retain control over population matters by virtue of their responsibility for U.N. functions within economic and social realms. *Id.* art. 60.

15. G.A. Res. 49/128, *supra* note 6. In December 1994, the General Assembly renamed the Population Commission the Commission on Population and Development. *Id.* The Commission functions as part of the Economic and Social Council. U.N. CHARTER art. 68. The Commission has been "extraordinarily influential in calling attention to the complexities and implications of demographic developments." Nafis Sadik, *The Role of the United Nations — From Conflict to Consensus*, in POPULATION POLICY: CONTEMPORARY ISSUES 193, 193 (Godfrey Roberts ed., 1990).

16. See Sadik, *supra* note 15, at 193-206 (discussing role of United Nations in development of population policy); RICHARD SYMONDS & MICHAEL CARDER, THE U.N. & THE POPULATION QUESTION: 1945-1970 33-206 (1973) (discussing involvement of United Nations with population policy); John W. Halderman, *Programs of the United Nations and Associated Organizations*, in POPULATION AND LAW: A STUDY OF THE RELATIONS BETWEEN POPULATION PROBLEMS AND LAW 389, 389-436 (Luke T. Lee & Arthur Larson eds., 1971) [hereinafter POPULATION AND LAW] (summarizing United Nations involvement with population policy).

17. *Report of the Ad Hoc Committee of Experts on Long-Range Programme of Work in the Field of Population*, U.N. Pop. Comm., 13th Sess., at 15, U.N. Doc. E/CN.9/182 (1964) [hereinafter *Ad Hoc Committee Report*]. "The [Population Commission] recognizes the major contributions of conferences and regional seminars to the development of the work of the United Nations in population fields. It recommends the holding of a World Population Conference each decade." *Id.*; see *Cairo Programme*, *supra* note 1, at 120 (reporting on 1995 ICPD held in Cairo, Egypt); *Report of the International Conference on Population*, U.N. Doc. E/Conf.76/19 (1984) [hereinafter *Mexico City Report*] (reporting on 1984 International Conference on Population held in Mexico City, Mexico); *United Nations World Population Conference*, U.N. Doc. E/Conf.60/19 (1974) [hereinafter *Bucharest Report*] (reporting on 1974 World Population Conference held in Bucharest, Romania); *World Population: Challenge to Development: Summary of the highlights of the World Population Conference*, U.N. ECOSOC, U.N. Doc. E/Conf.41/1 (1966) [hereinafter *Belgrade Report*] (reporting on 1965 World Population Conference held in Belgrade, Yugoslavia); *Proceedings of the World Population Conference*, U.N. ECOSOC, U.N. Doc. E/Conf.13/412 (1955) [hereinafter *Rome Report*] (reporting on 1954 World Population Conference held in Rome, Italy). The involvement of the United Nations with population issues extends beyond sponsorship of international conferences to encompass demographic research, and assistance in the development, implementation, and funding of population and family planning activities. Crane & Isaacs, *supra* note 6, at 295-96. "The success of the U.N. in legitimizing national population and related problems ranks among its major achievements in the past few decades." *Id.* at 296.

making that requires states' population policies to support women's right to informed choice.¹⁸ Informed choice is best understood by reference to informed consent,¹⁹ a legal doctrine that governs the relationship between health-care providers²⁰ ("providers") and their patients.²¹

A. *The United Nations and Population Policy-making*

Initially, due to the paucity of statistical information regard-

18. *Cairo Programme*, *supra* note 1, at 43-49.

19. *See supra* note 8 and accompanying text (defining informed choice by reference to informed consent).

20. FAY A. ROZOVSKY, *CONSENT TO TREATMENT: A PRACTICAL GUIDE* 65-66 (2d ed. 1990 & Supp. 1993). The doctrine of informed consent does not contemplate that "a physician will [always] be responsible for disclosing information to a patient. This is a task best carried out by the person to carry out the diagnostic, medical, or surgical intervention." *Id.* at 66.

21. Martin R. Studer, *The Doctrine of Informed Consent: Protecting the Patient's Right to Make Informed Health Care Decisions*, 48 *MONT. L. REV.* 85, 85 (1987).

Negligence in medical diagnosis or treatment gives rise to a cause of action for medical malpractice. Unauthorized medical treatment gives rise to a cause of action for battery. The doctrine of informed consent adds a remedy for patients with injuries that result from undisclosed risks, even though they consented to treatment and are unable to show negligent diagnosis or treatment.

According to the doctrine of informed consent, a physician may be held liable for a patient's injuries, absent medical negligence, if those injuries arose from risks which the physician should have disclosed when securing the patient's consent to treatment.

Id. at 85. *See generally* ROZOVSKY, *supra* note 20 (providing guidelines regarding informed consent for medical practitioners); RUTH R. FADEN & TOM BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* 274 (1986) (providing history of informed consent and discussing its foundations in moral and legal theory); JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 48-84 (1984) (summarizing development of informed consent through discussion of U.S. case law); Bernard M. Dickens, *Reproduction Law and Medical Consent*, 35 *U. TORONTO L.J.* 235 (1985) (discussing specific requirements of informed consent in context of reproduction law). This Note focuses its analysis of informed consent on U.S. law, which is representative of informed consent law in other developed countries. *See* Shane S. Monks, *The Concept of Informed Consent in the United States, Canada, England and Australia: A Comparative Analysis*, 17 *UNIV. QUEENSLAND L.J.* 222 (1993) (comparing case law regarding negligence theory of informed consent, legal standards for adequate disclosure, and subjective and objective standards of causation); Frances H. Miller, *Denial of Health Care and Informed Consent in English and American Law*, 18 *AM. J. L. & MED.* 37 (1993) (concluding that English and American law agree that disclosure of information regarding proposed health treatment is necessary, but disagree over how much disclosure is required). The literature regarding informed consent is, for the most part limited to considerations of law and practice in developed countries. *See* Barbara Mensch, *Quality of Care: A Neglected Dimension*, in *THE HEALTH OF WOMEN: A GLOBAL PERSPECTIVE* 235 (Marge Koblinsky et. al. eds., 1992) ("[V]ery little is actually known about the quality of health care in most developing countries.").

ing population size and distribution,²² the Population Commission focused its efforts on the development of statistical databases.²³ The first two U.N.-sponsored international population conferences reflected this technical approach to population.²⁴ Thereafter, the Population Commission contributed to the development of family planning programs²⁵ and the rela-

22. See DIXON-MUELLER, *supra* note 3, at 58 (discussing lack of "[r]eliable demographic statistics . . . in early postwar years"); Sadik, *supra* note 15, at 194 (noting concerns of United Nations with "developing a knowledge base and the capacity to examine the characteristics and implications of population growth and distribution").

23. *Population Commission Report*, U.N. Pop. Comm., 13th Sess., Supp. No. 9, at 33, U.N. Doc. E/CN.9/202 (1965). "The work of the U.N. in the population field up to the present time had been concerned mainly with the improvement, extension, and international compilation of demographic statistics and with research on trends of population and their interrelations with economic and social factors." *Id.* "Demographic statistics of adequate scope and satisfactory quality, properly evaluated and analysed, are essential as a basis for sound decisions on questions of population policy and planning of social and economic action." *Ad Hoc Committee Report*, *supra* note 17, at 9.

24. See *Belgrade Report*, *supra* note 17, at 3 (describing Belgrade Conference as "a major inter-disciplinary meeting attended by more than 450 experts in a wide range of scientific fields relevant to the investigation of population trends, the factors influencing them, and their consequences"); *Rome Report*, *supra* note 17, at 2 (describing Rome Conference as "a scientific meeting of individual experts"); see also Sadik, *supra* note 15, at 193-94 (summarizing 1954 and 1965 U.N.-sponsored international conferences on population); STEPHEN L. ISAACS, *POPULATION LAW AND POLICY: SOURCE MATERIALS AND ISSUES* 358 (1981) [hereinafter *POPULATION LAW AND POLICY*] (discussing 1954 and 1965 U.N.-sponsored international conferences on population); WORLD POPULATION POLICIES 1 (Jyoti Shankar Singh ed., 1979) (reporting on 1954 and 1965 U.N.-sponsored international conferences on population).

25. See, e.g., *Cairo Programme*, *supra* note 1, at 46-49 (discussing Programme objectives relative to family planning programs).

The aim of family-planning programmes must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods.

Id.; see DIXON-MUELLER, *supra* note 3, at 5 (defining role of family planning programs as "[providing] individuals and couples with the means to regulate their fertility more safely or effectively than indigenous methods may allow"). Family planning programs form an integral part of population policies because the availability of family planning services contributes to declines in overall fertility levels. *Report of the Secretary-General of the Conference: Recommendations of the Expert Group Meeting on Family Planning, Health and Well-being*, U.N. Preparatory Committee for the International Conference on Population and Development, 2d Sess., Prov. Agenda Item 4, at 5-6, 17, U.N. Doc. E/Conf.84/PC/7 (1993) [hereinafter *Family Planning*]; *Report of the Secretary-General of the Conference: Recommendations of the Expert Group Meeting on Population Policies and Programmes*, U.N. Pop. Comm. acting as the Preparatory Committee for the International Conference on Population and Development, 2d Sess., Prov. Agenda Item 3, at 5, U.N. Doc. E/Conf.84/PC/5 (1992) [hereinafter *Population Policies and Programmes*]; Paul Demeny, *Population Policy: The Role of National Governments*, 1 POP. DEV. REV. 147, 159-60 (1975) (discussing intrinsic role of family planning programs in governmental efforts to reduce

tionship between population growth and socio-economic development.²⁶ Attendees at the 1974 and 1994 U.N.-sponsored international population conferences approved action plans to guide population policy-making.²⁷

1. The 1974 World Population Conference: The World Population Plan of Action

The 1974 World Population Conference at Bucharest ("Bucharest Conference") marked the first instance where government representatives attended an international population conference in their official capacities.²⁸ Attendees at the Bucharest Conference approved the World Population Plan of Action ("WPPA").²⁹ The WPPA served as the basis for population policy-making until 1994, when the Cairo Conference adopted a new plan of action embodied in the Cairo Programme.³⁰

The WPPA sought to promote international communication and cooperation³¹ and invited national governments to

fertility). The Cairo Programme notes that "[f]amily-planning programmes have contributed considerably to the decline in average fertility rates for developing countries, from about six to seven children per woman in the 1960's to about three to four children at present." *Cairo Programme*, *supra* note 1, at 46. Today, approximately 89 percent of all governments provide at least some support for family planning programs and over 80 percent of contraceptive users receive their supplies and services from the public sector. *Fourth review*, *supra* note 2, at 58.

26. See, e.g., *Cairo Programme*, *supra* note 1, at 11, 15, 18-19 (discussing interrelationships between population and development).

27. *Id.* at 5-114; *Bucharest Report*, *supra* note 17, at 3-27. In 1994, the ICPD produced the Cairo Programme. *Cairo Programme*, *supra* note 1, at 5-114. The 1974 World Population Conference at Bucharest produced the World Population Plan of Action ("WPPA"). *Bucharest Report*, *supra* note 17, at 3-27.

28. See DIXON-MUELLER, *supra* note 3, at 67-68 (discussing significance of attendance by government representatives at Bucharest Conference). The first two world conferences on population were based on individual and not official government participation. See *supra* note 24 and accompanying text (discussing 1954 and 1965 U.N.-sponsored international population conferences); WORLD POPULATION POLICIES, *supra* note 24, at 1 (discussing attendance at 1954 and 1965 U.N.-sponsored international conferences on population).

29. *Bucharest Report*, *supra* note 17, at 3-27. The WPPA was a "document of considerable importance." POPULATION LAW AND POLICY, *supra* note 24, at 358.

30. See *Fourth review*, *supra* note 2, at 6 (anticipating that new action plan would be adopted in 1994 at ICPD). See also WORLD POPULATION POLICIES, *supra* note 24, at 1 (anticipating that new action plan would be adopted in 1994 at ICPD). Since its adoption, the WPPA has been reviewed every five years. *Fourth review*, *supra* note 2, at 6.

31. *Bucharest Report*, *supra* note 17, at 6-7.

adopt policies that would address population-related problems.³² The WPPA recognized the sovereign right of each nation to determine the content of its population policy, but required that such policies respect human rights.³³ The WPPA also recognized interrelationships between population and socio-economic development.³⁴ Further, the WPPA redefined the international human right to family planning.³⁵

32. *Id.*

33. *Id.* The WPPA recognized the sovereign right of each nation to determine the shape of its own population policy consistent with due respect for international human rights. *Id.* "The formulation and implementation of population policies is the sovereign right of each nation. This right is to be exercised in accordance with national objectives and needs and without external interference, taking into account universal solidarity in order to improve the quality of life of peoples of the world." *Id.*

34. *Bucharest Report*, *supra* note 17, at 7. "The explicit aim of the WPPA is to help coordinate population trends and the trends of economic and social development." *Id.* [P]opulation variables influence development variables and are also influenced by them; thus, the formulation of a World Population Plan of Action reflects the international community's awareness of the importance of population trends for socio-economic development, and the socio-economic nature of the recommendations contained in this Plan of Action reflects its awareness of the crucial role that development plays in affecting population trends

Id. "The basis for an effective solution of population problems is, above all, socio-economic transformation." *Id.* at 3.

35. *Id.* at 7. "All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so. . . ." *Id.* The international human right to family planning is also referred to as a reproductive right. See Rebecca J. Cook, *International Protection of Women's Reproductive Rights*, 24 N.Y.U. J. INT'L L. & POL. 645 (1992) (discussing history of reproductive rights); see also Lynn P. Freedman & Stephen L. Isaacs, *Human Rights and Reproductive Choice*, 24 STUD. FAM. PLAN. 18 (1993) (discussing history of reproductive rights); Berta E. Hernandez, *To Bear or Not to Bear: Reproductive Freedom as an International Human Right*, 17 BROOK. J. INT'L L. 309 (1991) (discussing establishment of reproductive rights in international human rights law related to individual rights to privacy, health, and equality). The origins of reproductive rights can be traced to a 1966 United Nations General Assembly Resolution. G.A. Res. 2211, U.N. GAOR, 21st Sess., Supp. No. 16, at 42, U.N. Doc. A/6316 (1966) (recognizing principle that "the size of the family should be the free choice of each individual family"). In 1968, the Tehran Proclamation on Human Rights stated that "[p]arents have a basic human right to determine freely and responsibly the number and spacing of their children." *Final Act of the International Conference on Human Rights*, at 4, U.N. Doc. A/Conf.32/41 (1968). In 1969, the Declaration of Social Progress and Development acknowledged the state's obligation to provide families with the "knowledge and means necessary to enable them to exercise their [reproductive] right[s]." *Declaration of Social Progress and Development*, G.A. Res. 2542, U.N. GAOR, 24th Sess., Supp. No. 30, at 50, U.N. Doc. A/7630 (1969). Reproductive rights were expanded to include individuals as well as couples and families in 1974. *Bucharest Report*, *supra* note 17, at 7. Reproductive rights were firmly established in international law in 1981. *Convention on the Elimination of All Forms of Discrimination Against Women*, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A.34/46 (1979) (entered into force Sept. 3, 1981). Subsequently, the WPPA

Despite twenty years of concerted attention to population policy issues stimulated by adoption of the WPPA, population-related problems continue.³⁶ Many nations remain unable to provide adequate food and shelter for their populations.³⁷ Economic development proceeds at uneven paces.³⁸ Natural and man-made disasters ravage the environment and deplete natural resources.³⁹ The continuing population-related problems shaped the debate regarding population policy-making at the Cairo Conference.⁴⁰

2. The Cairo Conference: The Cairo Programme

The Cairo Programme affirms the basic principles of the WPPA: (i) it recognizes the sovereign right of each nation to determine the shape of its population policy, while requiring that population policies respect human rights;⁴¹ and (ii) it acknowledges the existence of interrelationships between population and socio-economic development.⁴² Unlike the WPPA, however, the Cairo Programme's plan of action promises to sta-

recognized that women's ability to control their own fertility forms an important basis for the enjoyment of other human rights. *Bucharest Report*, *supra* note 17, at 7. Further, the Cairo Programme specified that reproductive rights include the right to make decisions concerning childbearing and fertility reduction free from discrimination, coercion, and violence. *Cairo Programme*, *supra* note 1, at 43.

36. *See, e.g., Cairo Programme*, *supra* note 1, at 9 (noting intensification of environmental degradation and increases in number of people living in absolute poverty during past two decades).

37. *See, e.g., id.* at 20 (noting that "widespread poverty remains the major challenge to development efforts"). "Investments in fields important to the eradication of poverty, such as basic education, sanitation, drinking water, housing, adequate food supply and infrastructure for rapidly growing populations, continue to strain already weak economies and limit development options." *Id.* at 20-21.

38. *See, e.g., id.* (noting that "[d]espite decades of development efforts, both the gap between rich and poor nations and the inequalities within nations have widened").

39. *See, e.g., id.* at 22-24 (discussing environmental degradation over past 20 years).

40. *Id.* at 9-12.

41. *Cairo Programme*, *supra* note 1, at 14.

The implementation of the recommendations contained in the Programme of Action is the sovereign right of each country, consistent with national laws and development priorities, with full respect for the various religious and ethical values and cultural backgrounds of its people, and in conformity with universally recognized international human rights.

Id.

42. *Id.* at 11, 15, 18-19. "The population and development objectives and actions of the present Programme of Action will collectively address the critical challenges and interrelationships between population and sustained economic growth in the context of sustainable development." *Id.* at 11.

bilize population growth through improvements in the status of women.⁴³

The Cairo Programme also focuses extensively on women's health issues.⁴⁴ Women's health and status are inseparable,⁴⁵ and improvements in women's health result in a decline in overall fertility levels.⁴⁶ Moreover, the Programme recognizes that women have been prevented from attaining the highest standards of reproductive health⁴⁷ and from exercising fully their reproductive rights⁴⁸ due to discrimination, inadequate education,

43. *Id.* at 15, 25-31. See *Expert Synthesis*, *supra* note 1, at 11 (suggesting that role and status of women play crucial role, in affecting demographic transition); *Family Planning*, *supra* note 25, at 4 (stating that role and status of women play crucial role in affecting demographic transition). The Cairo Programme devoted an entire chapter to gender equality, equity, and the empowerment of women. *Cairo Programme*, *supra* note 1, at 25-31. In addition, the Cairo Programme discussed improvements in women's status in connection with its chapter on women's health. *Id.* at 43-49. In comparison, the WPPA mentioned, in one sentence, that improvements in women's status may encourage smaller family sizes. *Bucharest Report*, *supra* note 17, at 14.

44. *Cairo Programme*, *supra* note 1, at 43-49, 60-61 (discussing reproductive health, reproductive rights, family planning, and safe motherhood); see Crane & Isaacs, *supra* note 6, at 302 ("The major thrust of Cairo [is] the shift to a reproductive health and rights approach to population policies and programs . . .").

45. WOMEN'S PERSPECTIVES ON FAMILY PLANNING, REPRODUCTIVE HEALTH, AND REPRODUCTIVE RIGHTS (United Nations Population Fund, Ottawa, Canada) Aug. 26-27, 1993, at 16 (declaring that women's health and status are inseparable); see Freedman & Isaacs, *supra* note 35, at 18 (stating that effective reproductive health programs must "treat [reproduction] as a lifelong process inextricably linked to the status and roles of women in their homes and societies").

46. See *Expert Synthesis*, *supra* note 1, at 11 (stating that improvements in women's health and education proved instrumental in overall fertility decline); *Family Planning*, *supra* note 25, at 8 (recognizing that improvements in quality of health services increases contraceptive use and subsequent fertility reduction).

47. *Cairo Programme*, *supra* note 1, at 11, 43. The Cairo Programme advances a "new comprehensive concept of reproductive health." *Id.* at 11. According to this new concept, reproductive health encompasses the:

[S]tate of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Id. at 43. According to this more expansive concept of reproductive health, "people become the essence of reproductive health, the *subjects* rather than the *objects*." DECLARATION, *supra* note 8, at 2. The understanding "also challenges the criteria for success adopted in the past by family planning programs, criteria that have emphasized [the number of] contraceptive acceptors rather than personal well-being." *Id.*

48. See *supra* note 35 and accompanying text (defining reproductive rights).

and inappropriate or poor-quality health care services.⁴⁹

In response, the Programme concludes that women must be free to control their own fertility.⁵⁰ Accordingly, the Programme promotes universal access to high-quality reproductive health care services that include family planning.⁵¹ The Programme

49. *Cairo Programme*, *supra* note 1, at 44 (listing factors that cause poor reproductive health).

Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives.

Id. See, e.g., Iain Aitken and Laura Reichebanch, *Reproductive and Sexual Services: Expanding Access and Enhancing Quality*, in *POPULATION POLICIES RECONSIDERED: HEALTH, EMPLOYMENT, AND RIGHTS* 127-92 (1994) (arguing that resources be directed toward expanding access and changing quality of reproductive services); Lynn P. Freedman & Deborah Maine, *Women's Mortality: A Legacy of Neglect*, in *THE HEALTH OF WOMEN: A GLOBAL PERSPECTIVE* 147, 147-70 (Marge Koblinsky et. al. eds., 1992) (discussing large number of girls and women who die each year due to their second-class status and concluding that socio-economic development alone will not reduce number of deaths, but that such deaths will only be eliminated when special attention is given to "plight of women as women"); Judith Timyan et. al., *Access to Care: More Than a Problem of Distance* in *THE HEALTH OF WOMEN: A GLOBAL PERSPECTIVE* 217, 217-33 (Marge Koblinsky et. al. eds., 1992) (describing access-related problems to adequate health care services for women to include sociocultural and informational issues such as religious restrictions, lack of awareness of basic health issues, women's low social and legal status, women's lack of self-esteem and sense of control, and women's perceived inappropriateness of available services. Mensch, *supra* note 21, at 235-53 (stating that quality of women's health care remains poor due to lack of attention to improving quality of existing services); CHARLOTTE F. MULLER, *HEALTH CARE AND GENDER* 171-72 (1990) (discussing lack of access to quality health services among low-income women, minorities, teenagers, drug users, and HIV-positive women living in United States).

50. *Cairo Programme*, *supra* note 1, at 15.

51. *Id.* at 12, 43-49. "All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015." *Id.* at 44. Specifically, the Cairo Programme's suggestions for high-quality health care services include the recommendation that states:

- (a) Recognize that appropriate methods for couples and individuals vary according to their age, parity, family-size preference and other factors, and ensure that women and men have information and access to the widest possible range of safe and effective family-planning methods in order to enable them to exercise free and informed choice;
- (b) Provide accessible, complete and accurate information about various family-planning methods, including their health risks and benefits, possible side-effects and their effectiveness in the prevention of the spread of HIV/AIDS and other sexually transmitted diseases;
- (c) Make services safer, affordable, more convenient and accessible for clients and ensure, through strengthened logistical systems, a sufficient and continu-

also urges states to develop population policies and family planning programs that promote the free and responsible exercise of reproductive rights.⁵² Further, the Programme encourages states to eschew incentive and disincentive schemes⁵³ because

ous supply of essential high-quality contraceptives. Privacy and confidentiality should be ensured;

(d) Expand and upgrade formal and informal training in sexual and reproductive health care and family planning for all health-care providers, health educators and managers, including training in interpersonal communications and counselling;

(e) Ensure appropriate follow-up care, including treatment for side effects of contraceptive use;

(f) Ensure availability of related reproductive health services on site or through a strong referral mechanism;

(g) In addition to quantitative measures of performance, give more emphasis to qualitative ones that take into account the perspectives of current and potential users of services through such means as effective management information systems and survey techniques for the timely evaluation of services;

(h) Family-planning and reproductive health programmes should emphasize breast-feeding education and support services, which can simultaneously contribute to birth spacing, better maternal and child health and higher child survival."

Id. at 48-49; see *Family Planning*, *supra* note 25, at 17 (defining elements of high-quality family planning programs); see also Judith Bruce, *Fundamental Elements of the Quality of Care: A Simple Framework*, 21 *STUD. FAM. PLAN.* 61 (1990) (summarizing elements of high-quality family planning programs).

52. *Cairo Programme*, *supra* note 1, at 44, 46-49.

It should be the goal of public, private and non-governmental family-planning organizations to remove all programme-related barriers to family-planning by the year 2005 through the redesign or expansion of information and services and other ways to increase the ability of couples and individuals to make free and informed decisions about the number, spacing and timing of births . . .

Id. at 48.

53. *Id.* at 46-48. In the 1960's, governments began to incorporate various forms of incentives and disincentives into their population policies in order to encourage or discourage particular forms of fertility behavior. Freedman & Isaacs, *supra* note 35, at 24. Incentives include tangible benefits such as cash sums and intangible benefits such as free sterilizations. JOHN A. ROSS & ELIZABETH FRANKENBERG, *FINDINGS FROM TWO DECADES OF FAMILY PLANNING* 40-43 (1993); John A. Ross & Stephen L. Isaacs, *Costs, Payments, and Incentives in Family Planning Programs: A Review for Developing Countries*, 19 *STUD. FAM. PLAN.* 270, 271 (1988). Incentives may be offered to the individual, the health care provider ("provider"), or the community. ROSS & FRANKENBERG, *supra*, at 42; Ross & Isaacs, *supra*, at 271; Henry P. David, *Incentives, Reproductive Behavior, and Integrated Community Development in Asia*, 13 *STUD. FAM. PLAN.* 159, 160 (1982). For example, a provider may receive a fixed sum for each woman sterilized or a community may receive additional funds, farming equipment, or land for reaching a specified reduction in the number of births per year. ROSS & FRANKENBERG, *supra*, at 31, 42; Ross & Isaacs, *supra*, at 271; David, *supra*, at 161. Disincentives include tangible sanctions or penalties, such as fines, or reductions in wages for giving birth to additional children. David, *supra*, at 161.

such schemes have not had a significant impact on overall fertility levels⁵⁴ and because such schemes violate the principle of informed choice.⁵⁵

54. *Cairo Programme*, *supra* note 1, at 46. "The use of financial payments as an instrument of reproductive control is one of the most controversial and divisive aspects of population policies." John Cleland & W. Parker Mauldin, *The Promotion of Family Planning by Financial Payments: The Case of Bangladesh*, 22 *STUD. FAM. PLAN.* 1, 1 (1991). One element of the debate regarding states' use of incentives and disincentives focuses on whether incentives and disincentives actually work. *Cairo Programme*, *supra* note 1, at 46; Freedman & Isaacs, *supra* note 35, at 26. "Most . . . [incentive and disincentive] schemes have had only marginal impact on fertility and in some cases have been counterproductive." *Cairo Programme*, *supra* note 1, at 46. "[Twenty-five] years of experience in organized family planning programmes showed that good quality services, with consistent political and administrative support and innovative public education efforts, could produce very rapid voluntary changes in reproductive behaviour in a wide variety of economic, political, social and religious settings." *Population Policies and Programmes*, *supra* note 25, at 5.

55. *Cairo Programme*, *supra* note 1, at 46. Another element of the debate regarding states' use of incentives and disincentives focuses on whether incentives are inherently coercive. Freedman & Isaacs, *supra* note 35, at 25; Ross & Isaacs, *supra* note 53, at 279-81. In addition, commentators question the effect of incentives on women's status. Freedman & Isaacs, *supra* note 35, at 25. "Nowhere is the collision of individual rights with government demographic priorities more starkly presented than in the instance of incentives and disincentives." *Id.*

Some argue that given the social and economic circumstances of poor people (especially poor women) in many less developed countries, a technically voluntary program, such as one that requires proof of sterilization as a condition for receipt of emergency food, becomes coercive in practice, since people's ability to meet their most basic needs depends on relinquishing reproductive choice. Others contend that in some poverty-stricken areas, payments in cash or kind enable people to exercise choices that would otherwise be beyond their means, so that these incentives facilitate reproductive autonomy. These analysts argue that ending incentive payments discriminates against the poor.

Id.; see, e.g., Cleland & Mauldin, *supra* note 54, at 4 (arguing that incentives allow people to exercise choices and thereby facilitating reproductive autonomy); BETSY HARTMANN, *REPRODUCTIVE RIGHTS AND WRONGS: THE GLOBAL POLITICS OF POPULATION CONTROL AND CONTRACEPTIVE CHOICE* (1987) (arguing that incentives become coercive when people have no reasonable alternative but to relinquish reproductive choice in order to satisfy basic needs). More specifically, commentators suggest that "[i]he extent to which monetary or other payments infringe upon the principle of voluntariness depends, in large measure, upon the payment amount in relation to the income level of the recipient." Ross & Isaacs, *supra* note 53, at 280. In other words, an incentive payment is coercive if it is so high that it induces people to accept fertility regulation when they would ordinarily choose otherwise. *Id.* Similarly, community incentives and payments to service providers "contain the seeds of coercion" because they allow room for intense peer pressure. *Id.* Moreover, because disincentives "restrict individual choice more than positive incentives do," commentators suggest that "[d]isincentives would appear to be justified only after positive incentives have not succeeded and when a societal consensus exists on such means of reducing population growth." *Id.* at 281. The Cairo Programme stresses that:

The aim of family-planning programmes must be to enable couples and indi-

The Programme repeatedly urges states to support women's right to informed choice.⁵⁶ Informed choice is an essential element of women's reproductive rights and is vital to the achievement of optimum health.⁵⁷ The Programme discusses informed choice within the context of reproductive health, reproductive rights, and family planning programs.⁵⁸ While the Programme does not define informed choice explicitly, it requires states to ensure that women are adequately informed about reproductive health-care services, including family planning,⁵⁹ and that women have access to safe, effective, and appropriate family planning methods of their choice.⁶⁰ Moreover, the Programme requires states to enable and support women's rights to make voluntary decisions about childbearing and fertility regulation⁶¹ and to ensure that women make reproductive choices free from discrimination, coercion, or violence.⁶²

viduals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so. . . . The principle of informed free choice is essential to the long-term success of family-planning programmes. Any form of coercion has no part to play.

Id.

56. *Cairo Programme*, *supra* note 1, at 15, 43-49, 60-61; *see Family Planning*, *supra* note 25, at 20 (recommending that purpose of family planning programs is to help women achieve their reproductive goals through voluntary, free, and informed choice).

57. *Cairo Programme*, *supra* note 1, at 43-49; DECLARATION, *supra* note 8, at 6; *see supra* note 8 and accompanying text (discussing informed choice).

58. *Cairo Programme*, *supra* note 1, at 43-49, 60-61.

59. *Id.* at 43. "The objectives are: To ensure that comprehensive and factual information and a full range of reproductive health-care services, including family planning, are accessible, affordable, acceptable and convenient to all" *Id.* at 44.

60. *Id.*

61. *See supra* notes 53-55 and accompanying text (discussing effects of incentives and disincentives on women's reproductive choices).

62. *Cairo Programme*, *supra* note 1, at 43-44. "The objectives are: . . . to enable and support responsible voluntary decisions about child-bearing and methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law and to have the information, education and means to do so" *Id.* at 44; *see supra* note 47 and accompanying text (defining reproductive health to include women's right to choose family planning methods); *see supra* note 35 and accompanying text (defining reproductive rights to include the right to "decide freely"); *see Cairo Programme*, *supra* note 1, at 43 (defining reproductive rights to include the "right to make decisions concerning reproduction free of discrimination, coercion and violence"). A woman's voluntariness may be compromised by familial pressures. *See, e.g.,* Rebecca J. Cook & Deborah Maine, *Spousal Veto over Family Planning Services*, 77 AM. J. PUB. HEALTH 339 (1987) (describing situation in many countries where spouse, usually husband, can veto partner's use of family planning services). For example, laws in Africa, Japan, Papua New Guinea, South Korea, and Turkey legitimize familial pressures by either barring the sale of contraceptives to married women with-

B. *Informed Choice and the Doctrine of Informed Consent*

Informed choice is more fully understood by reference to informed consent, a legal doctrine that affirms patients' rights to participate in the decision-making process regarding their own medical treatment.⁶³ According to the doctrine of informed consent, providers must disclose to their patients relevant, unbiased information regarding the patient's health status and treatment options.⁶⁴ In addition, before administering treatment,

out their husband's consent, requiring spousal consent for either partner to obtain sterilization, or requiring husband's consent for his wife to obtain an abortion. *Id.* at 340. A woman's voluntariness may also be compromised by financial pressures. *See, e.g.,* DECLARATION, *supra* note 8, at 5-6 (recognizing that individual's capacity to act voluntarily may be affected by poverty). "In social and economic conditions of deprivation and poverty, however, people are not fully able to deliberate and exercise informed reproductive choice." *Id.* at 5. "[W]hile financial incentives are not coercive for most persons, they are coercive for the very poor." ALAN WERTHEIMER, COERCION 68 (1987). "It might be claimed that . . . poverty compromises the *volitional* quality of decisions, that there is a general tendency for persons in such circumstances to underestimate the risks or overestimate the benefits." *Id.* (emphasis in original). Furthermore, "it might be argued that even if the poor . . . are capable of rationally weighing the alternatives, . . . their consent is given under duress nevertheless, because they have *no reasonable alternative* but to consent." *Id.* at 69 (emphasis added).

63. *See supra* note 21 and accompanying text (defining informed consent); *see, e.g.,* Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914) (Cardozo, J.) ("Every human being of adult years and sound mind has a [legal] right to determine what shall be done with his own body. . . ."). By acknowledging patients' right to participate in the decision-making process regarding their own medical treatment, informed consent operates to protect patients' bodily integrity and to ensure respect for patients' rights to autonomy and self-determination. *See, e.g.,* Inderbitzen v. Lane Hosp., 124 Cal. App. 462, 12 P.2d 744 (1932), *dismissed on other grounds*, 17 Cal. App. 103, 61 P.2d 514 (1936) ("A . . . physician has no more right to unnecessarily or rudely touch a patient than does a layman."); August Piper, Jr., *Truce on the Battlefield: A Proposal for a Different Approach to Medical Informed Consent*, 22 J.L. MED. & ETHICS 301 (1994) (stating that "deeply felt moral principles — the right of self-determination and the right to guard against invasion of one's privacy — breathe life into the doctrine" of informed consent); *but see* DIXON-MUELLER, *supra* note 3, at 50 (discussing existence of "traditional authoritarian model of service delivery in which 'patients' are passive recipients of 'expert' advice with which they are expected to comply"); Majorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest* 95 YALE L.J. 219, 221-23 (1983) (arguing that informed consent fails to protect patient autonomy and self-determination).

64. Rozovsky, *supra* note 20, at 46-47. "The physician's duty of disclosure is the principal component of informed consent." Studer, *supra* note 21, at 87. Most informed consent cases are decided in terms of the provider's duty to disclose. *See, e.g.,* Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976). "[W]e are content to accept, as the meaning [of informed consent], the giving of information to the patient as to just what would be done and as to its consequences." *Danforth*, 428 U.S. at 67 n.8.

providers must obtain a valid consent from their patients.⁶⁵ A provider will be held liable for lack of informed consent when undisclosed or improperly disclosed risks associated with a particular course of medical treatment cause injury.⁶⁶

1. The Health Care Provider: An Affirmative Duty to Disclose

Informed consent imposes an affirmative duty upon providers to disclose information to their patients regarding the probable outcomes and medically recognized risks associated with each proposed course of treatment.⁶⁷ A provider violates her legal duty to disclose when she fails to inform her patient of a

65. ROZOVSKY, *supra* note 20, at 12. There exists general agreement on the basic requirements for a valid consent: capacity, adequate knowledge, and voluntariness. *Id.*; Rasmussen v. Fleming, 154 Ariz. 207, 216, 741 P.2d 674, 683 (Sup. Ct. Ariz. 1987). Ultimately, the patient "retains the sole prerogative to make the subjective treatment decision." Thor v. Andrews, 5 Cal. 4th 725, 735, 855 P.2d 375, 381, 21 Cal. Rptr. 2d 357, 365 (Sup. Ct. Cal. 1993). A patient's consent to treatment may be express or implied. ROZOVSKY, *supra* note 20, at 32-35. Express consent occurs when a patient, by verbal or written authorization, agrees to undergo treatment. *Id.* at 32. Implied consent arises as a product of legal fiction, such as consent to emergency treatment. *Id.* at 33. Implied consent also arises from the surrounding facts or circumstances of a particular case. *Id.* For example, an individual who stands in line for a vaccination and rolls up her sleeve to expose her arm for the needle implies consent to treatment. *Id.* In addition, a patient's lack of objection, provided there was opportunity and ability to object, may also indicate consent to treatment. *See, e.g.,* Hernandez v. United States, 465 F. Supp. 1071 (D. Kan. 1979) (dismissing patient's informed consent claim where patient was awake through surgery and could have objected at any time); *but see* Tisdale v. Pruitt, 302 S.C. 238, 394 S.E.2d 857 (S.C. Ct. App. 1990) (finding lack of implied consent to medical treatment in patient's silent acquiescence where doctor failed to inform patient regarding nature of treatment).

66. Thomas A. Moore, *Informed Consent — Part I*, N.Y.L.J., Sept. 5, 1995, at 3, 7. The term "treatment" includes any invasive procedure performed by health care providers, such as physical examinations, diagnostic tests, and surgery, as well as the administration of drugs or contraceptives. *Id.*; *see, e.g.,* Truman v. Thomas, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (Sup. Ct. Cal. 1980) (finding lack of informed consent where physician failed to advise patient of risks involved in foregoing recommended diagnostic test). *See supra* note 21 (discussing informed consent).

67. ROZOVSKY, *supra* note 20, at 33. There exists no single, definitive list to guide disclosure and the law varies from state to state. *Id.*; Studer, *supra* note 21, at 88. One handbook suggests that providers disclose the following:

1. the likely outcome of diagnostic tests;
2. the likely benefits of diagnostic workups in determining a patient's illness or the extent of his or her injury;
3. the probable outcome of medical and/or surgical interventions;
4. the likely benefits from medical and/or surgical procedures;
5. an explanation of what a diagnostic, medical, or surgical procedure will involve, including any probable complications and any temporary discomfort, disability, or disfigurement;

particular risk⁶⁸ or alternate form of treatment,⁶⁹ or when she provides biased information about a particular procedure.⁷⁰ A patient subsequently injured by the undisclosed or improperly

6. an explanation of any permanent results of medical or surgical procedure . . . ; and
7. a disclosure of risks that are reasonable and foreseeable at the time that consent is obtained.

ROZOVSKY, *supra* note 20, at 33; see *Arato v. Avedon*, 13 Cal. App. 4th 1325, 1483-89, 11 Cal. Rptr. 2d 169, 173-78 (Cal. App. 1992) (discussing nature and scope of duty to disclose).

68. ROZOVSKY, *supra* note 20, at 59-62. Depending upon the jurisdiction, the trier of fact will use one of two standards of disclosure to determine whether adequate disclosure was made: the medical community standard or the patient-need standard. *Id.* According to the medical community standard, also known as the professional community standard, the adequacy of disclosure is determined by reference to the practice of other health care providers with similar backgrounds and areas of expertise. See, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972) (enunciating medical community standard of disclosure); *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960) (articulating medical community standard); see also ROZOVSKY, *supra* note 20, at 59-60 (discussing medical community standard of disclosure). "The precise scope of the physician's duty of disclosure is determined on the basis of expert testimony demonstrating the extent of information given by reasonably careful physicians practicing the same specialty in the same or similar community." *Bloskas v. Murray*, 646 P.2d 907, 914 (Colo. 1982). Prevailing custom is not always dispositive. See, e.g., *Cornfeldt v. Tongen*, 262 N.W.2d 684, 702 (Minn. 1977) (stating that "even if . . . disclosure conforms to accepted medical practice, a physician nevertheless should be liable if he fails to inform the patient of a significant risk of treatment or of an alternate treatment"). The patient-need standard, also known as the reasonable patient standard or patient-oriented standard, requires disclosure of material and significant information that a reasonable person in the patient's position would want or need to know in order to reach an informed decision. See, e.g., *Scott v. Bradford*, 606 P.2d 554 (Okla. 1979) (enunciating patient-need standard); see also ROZOVSKY, *supra* note 20, at 60-62 (discussing patient-need standard). The patient-need standard does not require disclosure of risks known to the patient, risks that are so obvious that it may be presumed that the patient knows of them, risks which are present but do not occur very often, and risks that the physician did not know at the time and could not ascertain with ordinary care. ROZOVSKY, *supra* note 20, at 60-61.

69. See, e.g., *Garone v. Roberts' Technical and Trade School Inc.*, 47 A.D.2d 306 (N.Y. App. Div. 1975) (finding lack of informed consent where physician failed to advise patient of alternatives to treatment); *Zelesnik v. Jewish Chronic Disease Hosp.*, 47 A.D.2d 199 (N.Y. App. Div. 1975) (holding physician liable for lack of informed consent where physician failed to advise patient of alternatives to treatment).

70. ROZOVSKY, *supra* note 20, at 31.

Providing patients with understandable explanations is a function of not only what is said, but also *how* details are presented. A negative spin or an overly optimistic explanation can taint the quality of the information imparted to the patient. From a practical perspective, the task of the caregiver is to aim for the middle of the road, providing information in a way that is neither inordinately gloomy nor excessively positive. The key is to enable the patient to make a treatment choice free of factors that obscure decision making.

Id.

disclosed risk will have a cause of action against her provider for lack of informed consent.⁷¹

The legal theory of informed consent assumes that the risks, if properly disclosed, would have prompted the patient to withdraw from treatment, thereby avoiding injury.⁷² Depending upon the circumstances, a patient may bring a cause of action for lack of informed consent based in negligence,⁷³ assault and battery,⁷⁴ or misrepresentation.⁷⁵

71. *Id.* at 73; see *supra* note 21 and accompanying text (discussing informed consent).

72. Rozovsky, *supra* note 20, at 73. Depending upon the jurisdiction, the trier of fact will use one of two standards of causality: objective or subjective. *Id.* at 73-74. The objective standard of causality measures what a reasonable person in the patient's position would have decided about undergoing treatment. *Id.*; see, e.g., *Canterbury*, 464 F.2d at 722 (finding plaintiff's testimony relevant but not decisive factor in consideration of what reasonably prudent person in patient's position would have done if fully informed). The subjective standard of causality measures what the individual patient wanted to know at the time she gave consent for a procedure. *Id.* at 73; see, e.g., *Scott*, 606 P.2d at 554 (providing support for subjective standard because objective test of causation limits protection extended by patient-need standard of disclosure).

73. Rozovsky, *supra* note 20, at 73. Today, most informed consent cases are brought under the theory of negligence. *Id.* at 10-11, 73. See Moore, *supra* note 66, at 3 (discussing negligence theory of informed consent). The basic elements of a negligent consent action include:

1. a failure by the health care provider to meet the applicable standard of disclosure;
2. proof that the patient consented to and underwent the procedure based upon the inadequate disclosure;
3. an indication that the patient was injured as a reasonably foreseeable consequence of the inadequate information; and
4. proof that had the patient been given all relevant information, she would not have authorized the procedure.

Rozovsky, *supra* note 20, at 11.

74. Rozovsky, *supra* note 20, at 6-9. Initially, the informed consent doctrine was advanced under the tort theory of battery. *Id.*; Schultz, *supra* note 63, at 224-25. See Moore, *supra* note 66, at 3 (discussing distinction between informed consent cases brought under theory of assault and battery and cases brought under theory of negligence). "[A] surgeon who performs an operation without his patient's consent, commits an assault for which he is liable in damages." *Schloendorff*, 211 N.Y. at 129-30, 105 N.E. at 93-94. The typical battery case of informed consent arises where no consent is given or where consent is given for a particular procedure and a different or additional procedure is performed. See, e.g., *Reddington v. Clayman*, 334 Mass. 244, 134 N.E.2d 920 (1956) (finding battery where consent given to remove tonsils and adenoids and provider removed uvula); *Hively v. Higgs*, 120 Or. 588, 253 P. 363 (1927) (finding battery where consent given to operate on septum of nose and provider removed tonsils); *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905) (finding battery where consent given to operate on one ear and provider operated on other ear). In most instances, however, the battery theory of informed consent proves unworkable because battery cannot be alleged where consent to treatment is given on the basis of inadequate infor-

2. The Patient: Three-Part Criteria for Valid Consent

The doctrine of informed consent requires providers to obtain a valid consent from their patients before administering treatment.⁷⁶ Three elements must be satisfied in order for a patient's consent to be valid: (i) the patient must possess the legal and mental capacity to consent;⁷⁷ (ii) the patient must be adequately informed;⁷⁸ and (iii) the patient must decide voluntarily to consent to treatment.⁷⁹ Failure to meet the requirements for a valid consent may create a cause of action for lack of informed

mation. ROZOVSKY, *supra* note 20, at 9; *see, e.g.*, *Nishi v. Hartwell*, 52 Haw. 188, 190-91, 473 P.2d 116, 118-19 (Haw. 1970) (locating action for informed consent in negligence and not battery where patient consented to treatment). Moreover, most providers lack the anti-social motivation associated with intentional torts, including battery. *Nishi*, 52 Haw. at 190-91, 473 P.2d at 118-19. Consequently, some states have completely abandoned the battery cause of action for lack of informed consent. *See, e.g.*, *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (rejecting battery theory of informed consent except where provider administers treatment to which patient has not consented).

75. ROZOVSKY, *supra* note 20, at 6-9. Even though the physician-patient relationship arises through contract, it is not normally governed by contract principles because medical treatment is not perceived to be susceptible to bargaining. Schultz, *supra* note 63, at 223-24 (citations omitted). Still, if a health care provider misrepresents material information, a patient may have a cause of action for lack of informed consent. ROZOVSKY, *supra* note 20, at 10. The elements of an informed consent claim, based on a theory of misrepresentation, include:

1. proof that the health care provider misrepresented or suppressed material details and possessed a knowledge of falsity;
2. proof that the health care provider intended to induce reliance on the misrepresented information;
3. proof that the patient actually and justifiably relied on the information; and
4. proof of resulting damages.

Id. *See, e.g.*, *Krueger v. San Francisco Forty-Niners*, 234 Cal. Rptr. 579 (Cal. Ct. App. 1987) (finding misrepresentation and fraudulent concealment where team physicians failed over several years to disclose nature and severity of degenerative knee condition to plaintiff football player).

76. *See supra* note 65 and accompanying text (discussing elements of valid consent).

77. ROZOVSKY, *supra* note 20, at 17-24. Capacity is defined as the ability to perform a task. *See* FADEN & BEAUCHAMP, *supra* note 21, at 287-88. "[C]ompetence functions as a gatekeeping concept for informed consent . . ." *Id.*

78. ROZOVSKY, *supra* note 20, at 31, 44-64 (discussing requirement that patient receive relevant, unbiased information regarding medical treatment in order to give valid informed consent).

79. *Id.* at 13-17 (discussing requirement that consent be voluntary and concluding that voluntariness may be compromised by, *inter alia*, financial constraints or inadequate communication).

consent.⁸⁰

The first requirement dictates that before administering treatment, a provider must determine her patient's capacity to consent.⁸¹ A legally or mentally incapable patient cannot consent to treatment.⁸² Absent judicial or legislative order, an adult patient is presumed to possess the legal and mental capacity to consent to treatment.⁸³

The requirement that patients be adequately informed reinforces the provider's duty to disclose⁸⁴ and recognizes that, in order to authorize treatment, patients must understand the risks, benefits, and side effects associated with all available treatment options.⁸⁵ Providers must present information in a lan-

80. *Id.* at 12-13; *see supra* note 21 and accompanying text (discussing informed consent).

81. *See* ROZOVSKY, *supra* note 20, at 17-24 (discussing requirement that patient possess capacity to consent to medical treatment). "Courts have generally held that a patient is competent to make his or her own medical choices when that patient is capable of 'the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each.'" *Canterbury*, 464 F.2d at 780.

82. ROZOVSKY, *supra* note 20, at 17-23. Mental incapacity is not commensurate with mental retardation. *See, e.g.*, *Matter of Romero*, 790 P.2d 819 (Sup. Ct. Colo. 1990) (invalidating court order authorizing sterilization sought by guardian of mildly retarded woman). Factors such as mental illness, shock, trauma, crippling physical injury, or alcohol or drug use, however, may substantially affect an adult patient's mental capacity to consent to treatment. ROZOVSKY, *supra* note 20, at 21; *see, e.g.*, *In re A.C.*, 573 A.2d 1235, 1239, 1247 (D.C. Ct. App. 1990) (noting inability of patient to give informed consent when heavily sedated). In addition, when the state compels treatment, such as when it requires venereal disease testing or immunization, the state deems patients legally incapable of giving or refusing to give consent. ROZOVSKY, *supra* note 20, at 20. Under such laws, it is not necessary to obtain a patient's consent before administering treatment. FADEN & BEAUCHAMP, *supra* note 21, at 288. Such legislative actions are typically justified as necessary to protect public health. ROZOVSKY, *supra* note 20, at 20.

83. ROZOVSKY, *supra* note 20, at 17, 21.

84. *See supra* notes 64, 67-75 and accompanying text (discussing provider's duty to disclose).

85. ROZOVSKY, *supra* note 20, at 12-13, 29-32, 44-64; *see, e.g.*, Bruce, *supra* note 51, at 64 (discussing information given to clients in family planning programs to include "information about the range of methods available, their scientifically documented contraindications, advantages, and disadvantages"). The therapeutic privilege allows providers the discretion to withhold information that, in their judgment, may adversely affect the patient's health status. ROZOVSKY, *supra* note 20, at 114-18 (discussing discretion given to providers to determine content of information conveyed to patients); *see, e.g.*, *Nishi*, 52 Haw. at 193, 473 P.2d. at 120 (affirming court's dismissal of informed consent claim where provider's failure to disclose risk justified by therapeutic privilege). If the following three criteria are not met, however, reliance on the therapeutic privilege is unjustified: "1. the provider must take into account the circumstances of the individual patient; 2. the provider must believe that full disclosure will have a signifi-

guage and terminology understandable to the patient.⁸⁶ Moreover, providers may not present such information in a biased manner.⁸⁷ Consent based on inadequate or improper disclosure is invalid.⁸⁸

Finally, in order for a patient's authorization of medical treatment to be considered valid, the patient must make a voluntary decision to authorize treatment.⁸⁹ A patient's authorization of medical treatment cannot be voluntary unless, at the very least, a patient possesses the capacity and information necessary to make a decision.⁹⁰ A patient's voluntariness may be compromised, however, by the unequal balance of power and knowledge between patient and provider.⁹¹

cantly adverse impact on the patient; and 3. the provider must use reasonable discretion." ROZOVSKY, *supra* note 20, at 115-16.

86. ROZOVSKY, *supra* note 20, at 29-30. A patient who is also a physician or a nurse, for example, will understand a more sophisticated explanation than a patient without any exposure to medical terminology. *Id.*; see *Medeiros v. Yashar*, 588 A.2d 1038 (Sup. Ct. R.I. 1991) (finding provider's discussion of mortality and morbidity statistics insufficient to allow for informed consent).

87. ROZOVSKY, *supra* note 20, at 31. While the provider may favor one particular procedure over another, she may not persuade the patient to accept the favored procedure by placing one option in a more positive or more negative light. *Id.*

88. *Id.*

89. See *supra* note 79 and accompanying text (discussing requirement of voluntariness for valid informed consent). "[O]ne acts voluntarily only when one's motivations are internal to the *self* or internal to the self in a certain way." WERTHEIMER, *supra* note 62, at 291 (suggesting two-pronged theory of coercion that examines coercive nature of proposals and choices). "It is uncontroversial that B [alleged subject of the coercion] acts freely and voluntarily when A's [alleged coercer] proposal increases B's options." *Id.* at 305. "One does not act involuntarily merely because one does not *like* the available alternatives . . . reluctance and voluntariness can well go hand in hand." *Id.* at 301 (emphasis in original). In other words,

B acts voluntarily when B succumbs to a proposal that A has a right to make, even if it is one which B finds unattractive and would prefer not to receive. Why? Because B *himself* is committed to the principles which grant A the right to make the proposal. On the other hand, B acts *involuntarily* when A makes an immoral proposal . . . because A's proposal attempts to get B to act contrary to his deep preference that he *not* be made to act in response to immoral proposals.

Id. at 301.

90. *Relf v. Weinberger*, 372 F. Supp. 1196 (D.D.C. 1974). Informed choice "entails a requirement that the individual have at his disposal the information necessary to make his decision and the mental competence to appreciate the significance of that information." *Relf*, 372 F. Supp. at 1202 (citations omitted); see *supra* notes 81-88 and accompanying text (discussing requirements of capacity and adequate information for valid informed consent).

91. See KATZ, *supra* note 21, at 1-29 (discussing effects of unequal balance of power and knowledge between patient and provider); WERTHEIMER, *supra* note 62, at 64 (ac-

It may be useful to conceptualize voluntariness along a continuum,⁹² from one end, where persuasion merely facilitates voluntary decision-making,⁹³ to the other end, where coercion precludes voluntary decision-making.⁹⁴ Between these two extremes exist varying degrees of manipulation, some more harmful to voluntariness than others.⁹⁵ With this framework in mind, a patient persuaded to accept medical treatment voluntarily consents to treatment, while a patient coerced into accepting medical treatment does not voluntarily consent.⁹⁶ If a patient does not consent to treatment voluntarily, the consent is invalid.⁹⁷

knowledging that pressure by physician to accept recommended treatment may compromise voluntariness of informed consent).

92. See FADEN & BEAUCHAMP, *supra* note 21, at 256-60 (proposing concept of voluntariness as continuum). *But see* Cleland & Mauldin, *supra* note 54, at 4 (criticizing continuum as unidimensional and oversimplified).

93. FADEN & BEAUCHAMP, *supra* note 21, at 259. "When persuaded by another, one willingly acts or accepts a belief as one's own." *Id.* "A *persuades* B to do X [some act] by giving B reasons to do X." WERTHEIMER, *supra* note 62, at 292 (emphasis in original). "It is . . . entirely uncontroversial that B acts voluntarily if he is persuaded by A's reasons . . ." *Id.* at 293. "What begins as an external force becomes thoroughly internalized, in a way that B knows about and to which he has given his direct and informed consent." *Id.*

94. FADEN & BEAUCHAMP, *supra* note 21, at 259. "Coercive interventions always entirely compromise autonomy by wholly controlling action." *Id.* See WERTHEIMER, *supra* note 62, at 185-88 (listing contexts in which coercion operates to control action). "In most legal contexts, a coercion claim involves an agent who is confronted with unwanted alternatives and makes an arguably rational choice among them — a choice which he may regret having to make (because of his circumstances) but which he will not regret having made (under the circumstances)." *Id.* at 171.

95. FADEN & BEAUCHAMP, *supra* note 21, at 259. "[D]eception, indoctrination, seduction, and the like are forms of manipulation." *Id.*; WERTHEIMER, *supra* note 62, at 292-93.

I do not suggest that B *always* acts involuntarily when A manipulates him, for . . . B's act may be perfectly voluntary. All I want to suggest . . . is that when A manipulates B — particularly by working through B's unconscious motivations — we think that the voluntariness of B's actions is debatable or at least of a different sort than when A persuades B.

Id. at 293.

When A *manipulates* B into doing X, B may not mind doing X, but he might, if he knew, mind doing X because A wants him to do X. B does not give his informed consent to that fully described action. A's manipulation compromises the voluntariness of B's action because it is not fully and accurately internalized.

Id.

96. FADEN & BEAUCHAMP, *supra* note 21, at 258.

97. ROZOVSKY, *supra* note 20, at 13-17.

3. The Patient's Right to Refuse or Withdraw From Treatment

As a corollary to the right to consent to treatment, patients possess the right to refuse particular treatment options, the right to forego all treatment, and the right to withdraw from treatment at any time.⁹⁸ In order for providers to obtain informed consent to treatment refusal or withdrawal, providers must disclose to their patients relevant, unbiased information regarding the risks and benefits associated with treatment refusal or withdrawal.⁹⁹

The three-part criteria for a valid consent applies equally to treatment refusals and withdrawals.¹⁰⁰ Consequently, if a provider fails to make adequate and proper disclosure,¹⁰¹ or if a patient lacks the legal or mental capacity to consent,¹⁰² or if a patient's decision to refuse or withdraw is not voluntary,¹⁰³ the consent to treatment refusal or withdrawal is invalid.¹⁰⁴ If injured, the patient may have a cause of action against her provider for lack of informed consent.¹⁰⁵

II. *POPULATION POLICIES OF CHINA AND THE UNITED STATES*

Faced with rapid population growth,¹⁰⁶ China announced the One-Child Family Policy¹⁰⁷ ("OCF Policy") because it deter-

98. *Id.* at 35-42; *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990).

99. ROZOVSKY, *supra* note 20, at 35-42.

100. *Id.*

101. *See supra* notes 64-65, 67-97 and accompanying text (discussing provider's duty to disclose and requirement that patients be adequately informed in order to give valid informed consent to medical treatment).

102. *See supra* notes 77, 81-83 and accompanying text (discussing requirement of legal and mental capacity in order to give valid informed consent to medical treatment).

103. *See supra* notes 89-97 and accompanying text (discussing requirement of voluntariness in order to give valid informed consent to medical treatment).

104. ROZOVSKY, *supra* note 20, at 35-42.

105. *Id.*

106. *See* Steven Mufson, *Population Curbs Slip in China*, WASH. POST, Feb. 14, 1995, at A17 (discussing population growth in China in 1994 when births out-numbered deaths by 13 million) [hereinafter *Population Curbs Slip*].

107. *See* CHINA'S SDI, *supra* note 11, at 49 (discussing China's One-Child Family Policy); CHINA'S ONE-CHILD FAMILY POLICY (Elisabeth Croll et al. eds., 1985) (summarizing China's One-Child Family Policy). The One-Child Family Policy is also referred to as the Single Child Family Policy and the One Child Policy. *See* AMNESTY INTERNATIONAL, WOMEN IN CHINA: IMPRISONED AND ABUSED FOR DISSENT 23 (1995) (referring to China's population policy as one-child policy); Delia Davin, *Gender and Population in the*

mined that it could not sustain more growth than that produced by single child families.¹⁰⁸ The Chinese Government asserts that planned reproduction in the form of limitations on family size ensures economic development and a better standard of living for its citizens.¹⁰⁹ In the United States, Aid to Families with Dependent Children¹¹⁰ ("AFDC") functions as an implicit population policy to the extent that AFDC legislation attempts to influence the reproductive behavior of AFDC recipients.¹¹¹ Today, a majority of the U.S. Congress advocates AFDC reform because, in their view, AFDC encourages illegitimacy and teenage pregnancy, and contributes to the impoverishment of Americans.¹¹²

People's Republic of China, in *WOMEN, STATE, AND IDEOLOGY: STUDIES FROM AFRICA AND ASIA* 111, 111-29 (Haleh Afshar ed., 1987) (referring to China's population policy as single child family policy).

108. CHINA'S SDI, *supra* note 11, at 116-17, 139.

109. Tyrene White, *Two Kinds of Production: The Evolution of China's Family Planning Policy in the 1980's*, in *THE NEW POLITICS OF POPULATION: CONFLICT AND CONSENSUS IN FAMILY PLANNING* 137, 141 (Jason L. Finkle & C. Alison McIntosh eds., 1994); CHINA'S SDI, *supra* note 11, at 91.

110. Social Security Act, tit. 4 § 401, 49 Stat. 627 (1935) (current version at 42 U.S.C. §§ 601-17 (1988 & Supp. V 1993)).

111. See *supra* note 11 and accompanying text (defining AFDC as implicit population policy of United States).

112. WOA, H.R. 4, 104th Cong., 1st Sess § 101(b) (proposed codification at 42 U.S.C. § 406 (a)(9)) (proposing AFDC reform to prevent "the crisis in our nation" related to illegitimacy and teenage pregnancy); PRA, H.R. 4, 104th Cong., 1st Sess §§ 100 (4) (1995) (noting that AFDC reform is compelled by "important government interest" in reducing illegitimacy and teenage pregnancy); *but see Prepared Statement of Rebecca Maynard, Trustee Professor of Education and Social Policy, University of Pennsylvania and Senior Fellow, Mathematica Policy Research, Inc. to the Senate Finance Committee, U.S. Senate*, Federal News Service, Mar. 14, 1995 available in LEXIS, Nexis library, CURNWS File [hereinafter *Prepared Statement*] (discussing lack of evidence regarding connection between AFDC benefits and teenage birth rates). "Teenage birth rates have more to do with poverty than with the generosity of welfare benefits." *Id.* Moreover,

There is no evidence that the exceptionally high teenage birth rate in the U.S. relative to other countries is due to our welfare policies. Our welfare policies tend to be less generous than those of most of the other industrialized countries. Within this country we see no positive correlation between state welfare benefits and teenage birth rates. Moreover, we have seen the trends in teenage birth rates moving in the opposite direction from trends in real welfare benefits.

Id. In addition,

The rise in the incidence of teenage pregnancy and childbearing in the U.S. is largely a function of increases in the incidence of sexual activity and reductions in abortion rates. Teenage pregnancy and birth rates have been rising fairly rapidly over the past five years. In 1992, there were 62 births per 1,000 teenage girls, compared with only 50 births per 1,000 in 1986 — a 24 percent

A. China's One-Child Family Policy

In early 1995, China's total population surpassed the target of 1.2 billion set for the year 2000.¹¹³ In response, the Chinese Government established a new target of 1.294 billion for the year 2000.¹¹⁴ In order to achieve its goal, the Chinese Government announced a new family planning program¹¹⁵ and reaffirmed its commitment to the OCF Policy.¹¹⁶

increase. During this period, the proportion of out-of-wedlock births to teenagers increased from 61 to 69 percent (13 percent).

Id.

113. See *Population Curbs Slip*, *supra* note 106, at A17 (discussing population growth in China where population continues to grow by 1.1 percent per year). The total population target was surpassed five years early even though China's birth rate fell from 21 births per 1000 in 1990 to approximately 18 births per 1000 in 1993. See Lena H. Sun, *China Lowers Birth Rate to Levels in West*, WASH. POST, Apr. 22, 1993, at A1 (discussing China's efforts to reduce population growth rates). Before 1949, birth rates ranged from below 20 to above 50 per 1000. CHINA'S SDI, *supra* note 11, at 49. The 1.2 billion target was set by the Chinese Government in accordance with what it believed to be the nation's approximate ability to feed, clothe, and shelter its population. *Id.* at 87-88, 139; see *White*, *supra* note 109, at 143 (discussing establishment of 1.2 billion target for year 2000). The long term goal of the Chinese government is to reach an optimum population of 700 million. CHINA'S SDI, *supra* note 11, at 139; *Population Curbs Slip*, *supra* note 106, at A17.

114. See Steven Mufson, *Chinese Leader Presses Call for 'One Couple, One Child'*, WASH. POST, Mar. 21, 1995, at A11 [hereinafter *Chinese Leader Presses Call*] (discussing establishment of new target for population growth).

115. See *Population Curbs Slip*, *supra* note 106, at A17 (discussing institution of new family planning program in China). The new family planning program aims to cut China's population growth rate to one percent in order to ensure that the population count stays within 1.3 billion by the year 2000. *Id.*

116. See *Chinese Leader Presses Call*, *supra* note 114, at A11 (discussing statements made by President and Communist Party Chief Jiang Zemin). During a speech carried on the front page of major government-controlled newspapers, Zemin condemned publicly those government officials who violate China's One-Child Family Policy: *Id.* Zemin underscored the negative effects of population growth: "The rapid increase and big population base have a direct bearing on the problems of food, of jobs, of education, of resource destruction, of environmental protection and an imbalanced ecology." *Id.* Zemin also emphasized the Policy's advantages for women and stressed its importance to the movement for women's liberation. *Id.*; see *White Paper: "The Situation of Chinese Women,"* BRITISH BROADCASTING CORPORATION SUMMARY OF WORLD BROADCASTS, June 11, 1994, at 3 (reprinting text released by The Information Office of the State Council in China) [hereinafter *White Paper*] (discussing improvements in women's status and women's reproductive rights in China). The Chinese Government asserts that today:

Women's rights to decide whether or not to bear children are duly protected. In old China, women were just child bearing tools, and they were often persecuted by their parents-in-law or abandoned by their husbands because they were unable to provide any offspring, let alone a son. In New China, women are in control of their own child bearing and they can discuss with their

The OCF Policy, adopted by the Chinese Government in 1979,¹¹⁷ requires couples to limit their family size to one child.¹¹⁸ The OCF Policy represents the culmination of family planning activities¹¹⁹ focused on encouraging *wan* — later marriages, *xi* —

spouses whether or not they will go through with a pregnancy. Historically, Chinese women were victims of early marriage and burdened by excessive numbers of offspring. They display great enthusiasm for the state's family planning policy and the overwhelming majority of them are willing to marry late and have children late and to have fewer children so as to guarantee a better quality of life for them.

White Paper, supra, at 3.

117. CHINA'S SDI, *supra* note 11, at 87, 117. The One-Child Family Policy was adopted in the form of a general directive to the public. *Id.* The Policy, not set forth in any public legislation, is a combination of general guidelines issued by the Chinese Government and detailed regulations issued by the provinces. *Id.* at 118, 122; see AMNESTY INTERNATIONAL, *supra* note 107, at 23 (describing complexity of China's population policy). "While the central authorities issue ideological directives, targets and guidelines, at present the detailed regulations, sanctions and incentives are left almost entirely to the county level administration, who determine them 'according to the local situation.'" *Id.*; see Karen Hardee-Cleaveland & Judith Banister, *Fertility Policy and Implementation in China, 1986-88*, 14 *POP. DEV. REV.* 245, 252 (1988) [hereinafter *Fertility Policy in China*] (discussing links between national, provincial, and local population plans). "Chinese leaders have stressed that the one-child policy is just that — a policy, not a law to be enforced throughout China without regard to local conditions. Guidelines issued at the central level are to be adapted to the specific conditions in each province and local area." *Id.* at 252; see, e.g., Birth Planning Regulations, 5th Shanxi Provincial People's Congress, Shanxi Province, China (1982), translated in 9 *POP. DEV. REV.* 553, 554-60 (1983) [hereinafter Birth Planning Regulations] (discussing Shanxi Province's family planning policy).

118. See Davin, *supra* note 107, at 111 (discussing China's population policy). Couples who bear and raise only one child are considered one-child parents. Birth Planning Regulations, *supra* note 117, art. 5, 9 *POP. DEV. REV.* at 555-56. A child of such couple is considered an only child. Birth Planning Regulations. *Id.* The following couples are also considered one-child parents: remarried couples who have only one child and chose not to have a second child, couples who had two or more children but because of death or other reasons have only one child and choose not to have another, couples who have no children but have chosen to adopt one child, couples who bear another child after their only children are dead and chose not to have any more. *Id.* Couples must obtain official permission to bear children. AMNESTY INTERNATIONAL, *supra* note 107, at 23. Quotas established by the Chinese Central Government fix the number of children that may be born annually in each province. *Id.*

119. White, *supra* note 109, at 137 (discussing actions by Chinese Government to propagate birth control and encourage fertility reduction during 1950's and 1960's). The Chinese Government became involved with family planning activities during the 1950's and 1960's. *Id.*; CHINA'S SDI, *supra* note 11, at 83-97 (discussing history of China's population policy prior to announcement of One-Child Family Policy); Elisabeth Croll, *Introduction: Fertility Norms and Family Size in China*, in CHINA'S ONE-CHILD FAMILY POLICY, *supra* note 107, at 1, 3-34 (documenting phases of Chinese government's involvement with family planning during 1950's and 1960's). At that time, the Chinese Government promoted family planning as a means to protect and promote the welfare of women and children. CHINA'S SDI, *supra* note 11, at 83.

longer intervals between births, and *shao* — fewer births.¹²⁰ Originally, *shao* favored small families, but did not limit families to one child.¹²¹ Today, *shao* allows for only one child per family.¹²²

In the 1970's, political change¹²³ and economic reform,¹²⁴ coupled with the population boom of the 1960's,¹²⁵ prompted the Chinese Government to examine the effects of population growth on its plans for economic development.¹²⁶ The Chinese

120. CHINA'S SDI, *supra* note 11, at 23-45, 87 (discussing Chinese Government's policy of *wan, xi, shao*, translated as later marriages, longer intervals between births, and fewer births); Croll, *supra* note 119, at 20-23 (discussing introduction during 1970's of "new nation-wide model of family size . . . encapsulated by the slogan 'late, spaced and few'").

121. CHINA'S SDI, *supra* note 11, at 87. Specifically, the Chinese Government mandated that, with respect to fewer births, "one is not wanting, two are good, three are excessive." *Id.* at 106. At that time, the Chinese Government approved of two child families. See Croll, *supra* note 119, at 20-21 (discussing allowance for two births per family).

122. CHINA'S SDI, *supra* note 11, at 96-97, 102. The Chinese Government changed its interpretation of *shao* from "one is best" to "one is enough." *Id.* The strict one child limit was relaxed in the late 1980's to permit rural families to have two children if the first child was a daughter. *Id.* Third births, however, were, and still are, never permitted. *Id.*; JUDITH JACOBSEN, PROMOTING POPULATION STABILIZATION: INCENTIVES FOR SMALL FAMILIES 27 (1983) (discussing government statements promoting one-child norm, allowing second children in limited circumstances, forbidding third children).

123. See White, *supra* note 109, at 139-44 (describing China's political climate of late 1970's). The One-Child Family Policy emerged during the period of transition in the wake of Mao's Zedong's death. *Id.* at 140. At that time, Hua Guofeng and Deng Xiaoping were engaged in a struggle to determine political superiority in post-Mao China. *Id.* at 140-44. Hua, a conservative, acted as Mao's appointed successor as party chairman. *Id.* at 141-42. Deng's successes in getting economic reform measures passed by the Party Central Committee severely undercut Hua's authority. *Id.* at 142.

124. See *id.* at 141-44 (describing Deng's plans to readjust and restructure economy). Deng's economic reforms included plans to "shift investment away from heavy industrial development toward other sectors of the economy." *Id.* at 143. In addition, Deng called for improvements in rural living standards and incomes. *Id.* at 144.

125. CHINA'S SDI, *supra* note 11, at 106. In the 1960's, China experienced the largest baby boom of all times, in any nation. *Id.* at 53. The total birth rate rose from 40 per 1000 in 1950 to 50 per 1000 in 1963. Davin, *supra* note 107, at 111. The number of babies born in China from 1962-69 equalled the total population of the United States in the 1970's. CHINA'S SDI, *supra* note 11, at 53. The Chinese Government anticipated that the population boom of the 1960's would result in peaks in population growth rates during the 1980's and 1990's as baby-boomers got married and had children. *Id.*; see *Fertility Policy in China*, *supra* note 117, at 245 (discussing China's efforts to strengthen family planning programs in anticipation of fertility peak).

126. White, *supra* note 109, at 139. With economic modernization as its primary task, the Chinese Government stressed the need to align population growth with its plans for economic development. *Id.*; CHINA'S SDI, *supra* note 11, at 102; Croll, *supra* note 119, at 1, 23.

Government concluded that rapid and uncontrolled population growth adversely affected its plans for economic development and determined to regulate human reproduction in order to achieve better standards of living for its citizens.¹²⁷

Consequently, the Chinese Government incorporated population growth targets into its five-year development plan for 1971-75,¹²⁸ and, in 1978, the People's Congress¹²⁹ adopted a new Constitution of the People's Republic of China in which it declared officially its dedication to family planning.¹³⁰ The Chinese Government also established quantitatively exact targets for

127. CHINA'S SDI, *supra* note 11, at 91, 99. The Chinese government concluded that planned reproduction was the only way for China to speed up production, create material wealth, improve living standards, and attain power, prestige, and affluence. White, *supra* note 109, at 141; CHINA'S SDI, *supra* note 11, at 22, 86, 91. In 1977, China's Office of Population Theory Research and the Beijing College of Economics published *Renkou Lilun*, or Population Theory, which advocated the view that human reproduction be regulated to the same extent as the production of goods and services in a planned economy. *Renkou Lilun*, translated in POPULATION THEORY IN CHINA 21-80 (H. Yuan Tien trans. & ed., 1980) (translating chapters five through seven) [hereinafter *Renkou Lilun*]; see CHINA'S SDI, *supra* note 11, at 91 (discussing *Renkou Lilun*). This theory is also referred to as the principle of proportionality of production and reproduction. CHINA'S SDI, *supra* note 11, at 91. "Like material production, where numerical targets were routinely used to set output levels and standards of performance, quarterly, annual and five year targets for childbearing would be passed down to local cadres." White, *supra* note 109, at 141. Moreover, this theory contrasts with the Maoist theory that "emphasized the advantages of a large and growing population and . . . exuded confidence in the country's ability to take care of the same." CHINA'S SDI, *supra* note 11, at 20.

128. White, *supra* note 109, at 141; CHINA'S SDI, *supra* note 11, at 21, 87. The Chinese Government incorporated population planning targets into its Fourth Five-Year Plan, covering the period 1971-75, and into every succeeding Five-Year Plan. See White, *supra* note 109, at 141-42 (discussing incorporation of population planning targets into Fourth Five-Year Plan); *Fertility Policy in China*, *supra* note 117, at 248-49 (discussing incorporation of population planning targets into Sixth and Seventh Five-Year Plans).

129. LAW IN THE PEOPLE'S REPUBLIC OF CHINA 21-29 (Ralph H. Folsom & John H. Minan eds., 1989) (discussing constitutional law in China) [hereinafter LAW IN THE PRC]. The People's Congress is the parliament of the Chinese government. Jay Matthews, *Chinese Constitution Urges Birth Control*, WASH. POST, Mar. 8, 1978, at A22.

130. CHINA'S SDI, *supra* note 11, at 100 (stating that 1978 Constitution declared that "the state advocates and encourages birth planning"). On December 4, 1982, the Fifth session of the Fifth National People's Congress adopted a new Constitution of the People's Republic of China, declaring that "[t]he states promotes family planning so that population growth may fit the plan for economic and social development." CHIN. CONST. ch. I, art. 25 (1982); LAW IN THE PRC, *supra* note 129, at 21, 951 (discussing constitutional law and providing official translation of 1982 Constitution of People's Republic of China). In addition, the 1982 Constitution sets forth couple's legal duty to use family planning. CHIN. CONST. ch. II, art. 49 (1982) ("Both husband and wife have the duty to practise family planning."); LAW IN THE PRC, *supra* note 129, at 954.

overall population growth.¹³¹ The establishment of a 1.2 billion ceiling on population growth by the year 2000,¹³² recently increased to 1.294 billion,¹³³ necessitated limits on individual family size.¹³⁴ In order to enforce these limits, the National Family Planning Commission ("Commission")¹³⁵ formulates systematic measures for the administration and implementation of family planning goals.¹³⁶ The Commission also provides for outreach to rural communities.¹³⁷ In order to ensure that women have

131. CHINA'S SDI, *supra* note 11, at 86-89, 93. Population planning in China became quantitatively exact when the inclusion of population planning in development plans necessitated quantitative targets. White, *supra* note 109, at 141; *see supra* note 128 and accompanying text (discussing inclusion of population planning in China's five-year development plans).

132. *See* CHINA'S SDI, *supra* note 11, at 134-35 (discussing debate regarding target of 1.2 billion). *See supra* note 113 and accompanying text (discussing 1.2 billion target).

133. *See supra* note 114 and accompanying text (discussing increase of 1.2 billion population growth target to 1.294 billion).

134. CHINA'S SDI, *supra* note 11, at 116-17, 139. The only conceivable way to reach this target was to strictly limit births to one child per family. *Id.* In this way, "[t]he one-child limit . . . was a logical progression in the refining of population planning tactics with Chinese characteristics, especially when the goal . . . was redefined in terms of numerically specific numbers by a certain date." *Id.* at 106; *see* White, *supra* note 109, at 137-58 (discussing development of One-Child Family Policy).

135. CHINA'S SDI, *supra* note 11, at 163. The Chinese Government created the National Family Planning Commission ("Commission") when it elevated the Family Planning Leading Group to ministerial status. Joan Kaufman et. al, *The Creation of Family Planning Service Stations in China*, 18 INT'L FAM. PLAN. PERSP. 18, 19 (1992). The Commission is responsible for the administration of nationally-sponsored family planning programs. *Id.* at 131. The Commission unifies management of national population planning activities, implements national population planning guidelines, formulates long term and annual population plans, and supervises implementation of population plans. *Id.* The Commission attained cabinet status in 1981. *Id.*

136. CHINA'S SDI, *supra* note 11, at 113. The Commission organizes birth planning leadership groups in each political unit to direct birth planning programs. *Id.* at 163; JACOBSEN, *supra* note 122, at 27. The administration of China's One-Child Family Policy requires thousands of provincial and local branches including rural villages and factory work teams. CHINA'S SDI, *supra* note 11, at 163. Local party officials known as cadres are responsible for monitoring the family planning affairs of their province. AMNESTY INTERNATIONAL, *supra* note 107, at 23. Since 1991, cadres have been held directly responsible for implementation of the Policy through a system referred to as "target management responsibility contracts." *Id.* Thus, a cadres' performance is evaluated on the region's economic performance as well as its ability to maintain low fertility rates. *Id.*

137. JACOBSEN, *supra* note 122, at 27. Teams consisting of party officials, midwives, and health workers called "barefoot doctors" visit rural areas to advocate the One-Child Family Policy. *Id.* In the 1990's, the Commission established family planning service stations throughout the country. Kaufman, *supra* note 135, at 18. Officials track women's reproductive cycles. *Id.* During the 1980's

the practical means to regulate their fertility in accordance with the OCF Policy, local family planning officials and health workers provide access to methods of fertility control.¹³⁸

The Chinese Government cautions against the use of coercion to obtain compliance with the OCF Policy and asserts that the OCF Policy allows for voluntary decision-making.¹³⁹ Never-

A thorough infrastructure for the delivery of free contraceptive services was established . . . in most of the country. Sterilization, IUD insertion and abortion services were provided through the primary health care system at village, township and county health institutions; oral contraceptives and barrier methods were provided through a community-based distribution system.

Id. Prior to 1981,

The [Family Planning Leading Group] maintained a network of planned-birth offices maintained at provincial, prefecture, county and township levels. These offices, through a corps of village-based part-time workers, conducted family planning mobilization and promotion, maintained records of eligible women and their contraceptive practice, and in some places, distributed barrier contraceptives and birth control pills. To back up their policy, the planned birth offices depended on local health institutions to ensure wide availability and easy access to all family planning services.

Id. at 19.

138. See *supra* note 137 and accompanying text (discussing provision of family planning services). In 1994, the Information Office of the State Council reported that the "contraception rate among married women reach[ed] 83% in the country as a whole and over 90% in some places." *White Paper, supra* note 116, at 3. In rural areas, the predominant methods of fertility control are female sterilization and the intrauterine device ("IUD"). Kaufman, *supra* note 135, at 20. The IUD is a small device that fits inside the uterus, made of copper, synthetic progesterone, or white plastic with strings attached. BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *OUR BODIES, OURSELVES* 295 (1992) [hereinafter *OUR BODIES, OURSELVES*]. The IUD is considered a very effective form of birth control with the typical failure rate at only three percent. *Id.* One major drawback is its high expulsion rate: within one year of use, between two and twenty percent of women will have expelled their IUDs, sometimes without knowing the expulsion occurred. *Id.* The device must be replaced every four or five years. *Id.* at 296. Though reversible, the IUD can damage fertility by perforating or embedding in the uterus or by stimulating pelvic inflammatory disease. *Id.* Some women have died from IUD complications and others have suffered serious injuries. *Id.* IUDs cannot be used by women with anemia, endometriosis, severe menstrual cramps or bleeding, small uterus, or heart disease. *Id.* IUDs also should not be used by women with an impaired response to infection or by women who suffered an infection following an abortion within the past three months. *Id.* at 296-97. Complications include infections, increased menstrual bleeding, excessive and painful cramping, and backaches. *Id.* at 297.

139. See, e.g., White, *supra* note 109, at 145 (discussing China's official disavowal of coercion in its sterilization campaign). Despite assurances from the State Family Planning Commission that coercion is not permitted, Amnesty International reported that it was "unable to find any instance of sanctions taken against officials who perpetrate violations." AMNESTY INTERNATIONAL, *supra* note 107, at 25. Amnesty International reported the harsh treatment of those who "assist women to circumvent policies or who shelter women from threat of forced abortion and sterilization." *Id.* For example, a deputy director of a hospital was sentenced to death for collecting bribes for issuing

theless, the Commission requires that women be fitted with intrauterine devices¹⁴⁰ ("IUDs") after the birth of their first child.¹⁴¹ Further, women pregnant with their second or third child are required to undergo abortions,¹⁴² and women with two or more children are required to submit to sterilization.¹⁴³

In addition to providing family planning services, each province establishes a scheme of incentives and disincentives¹⁴⁴ by

bogus sterilization papers. *Id.* Another man was sentenced to 10 years imprisonment for assisting 20 women to give birth in excess of plan allotments. *Id.*

140. See *supra* note 138 and accompanying text (defining IUD).

141. See, e.g., *Ying v. Caplinger*, 1995 WL 143830, at *9 (E.D. La. Mar. 30, 1995) (documenting experiences of 13 Chinese men and women seeking asylum in United States due to persecution as a result of China's One-Child Family Policy). Dai Xiu Ying testified that "[f]ollowing the birth of her first child, official's [sic] instructed her to have an intrauterine device inserted to avoid another pregnancy." *Ying*, 1995 WL 143830, at *9. Petitioner Li Bao Yu testified that "following the birth of her first child, she was forced to use an IUD. Following the insertion of the IUD, her health worsened. When the local cadres refused to have the IUD removed, she arranged to have it removed privately." *Id.* at *19. IUDs are often inserted without a tail so that they cannot be removed by anyone but a professional. JACOBSEN, *supra* note 122, at 27. X-rays are also used to ensure that women have not had their IUDs removed. *Id.*

142. AMNESTY INTERNATIONAL, *supra* note 107, at 23. Local officials often use intimidation and harassment to persuade women pregnant with their second child to have abortions. *Id.* Groups of family planning officials may visit women in the middle of the night. *Id.* Local militia and family planning officials may surround villages and search houses to gather all pregnant women together and take them to the hospital to have abortions. *Id.*; see, e.g., *Ying*, 1995 WL 143830, at *22 (recounting testimony of Sai Jin Lin). When Sai Jin Lin was five or six months pregnant, "the authorities discovered her situation and forced her to undergo an abortion and to have another IUD inserted." *Id.* Abortion is mandated for unmarried women. AMNESTY INTERNATIONAL, *supra* note 107, at 24.

143. AMNESTY INTERNATIONAL, *supra* note 107, at 23. Couples who already have two children must undergo sterilization of either the husband or the wife. *Id.* There is usually little choice in the matter. See *id.* (quoting Jiangxi Province's regulations promulgated in 1993 indicating "women who should be subjected to sterilization will have to comply"); see, e.g., *Ying*, 1995 WL 143830, at *13 (recounting testimony of Li Chun Nan). Li Chun Nan testified that "three months after the birth of her second son, village officials told her to report for sterilization. She ignored the notice. In response, officials forcibly removed her from home and sterilized her against her will." *Id.* Most women are sterilized immediately following an abortion. AMNESTY INTERNATIONAL, *supra* note 107, at 24; see, e.g., *Ying*, 1995 WL 143830, at *10 (recounting testimony of Qu Yun Lian).

144. See *supra* note 53 and accompanying text (defining incentives and disincentives); CHINA'S SDI, *supra* note 11, at 93-96 (discussing adoption of incentives and disincentives at province level). Soon after the One-Child Family Policy was announced, almost all provinces and municipalities adopted formal regulations governing second births. CHINA'S SDI, *supra* note 11, at 121. See, e.g., Birth Planning Regulations, *supra* note 117, art. 2, 9 POP DEV. REV. at 554-55 (providing that "[e]xcept in special circumstances where the birth of a second child is approved, state cadres, staff and workers and urban residents are allowed only one child per couple"). A representative from the

which couples are rewarded for limiting their family size to one child.¹⁴⁵ Because the Commission relies on local provinces to enforce the OCF Policy, the Policy is implemented to varying degrees by region.¹⁴⁶ Generally, once a couple pledges to have only one child,¹⁴⁷ the couple may receive rewards such as yearly

Guangdong Province first advocated the use of incentives and disincentives to promote population planning in 1978 during the First National Conference on the Science of Population Theory. CHINA'S SDI, *supra* note 11, at 93. She argued that the State had a right to intervene in reproductive choices because citizens in a welfare state have a duty to help lower the costs of entitlement. *Id.* At the same time, representatives from the Gansu Province promoted the use of incentives and disincentives in order to overcome the contradictions between China's population and socio-economic policies. *Id.* at 93-94. They argued that because cash and grain were distributed by reference to the number of persons in the household, couples had no motivation to practice family planning. *Id.*

145. See *Fertility Policy in China*, *supra* note 117, at 254-55 (discussing benefits given to one-child parents and their children).

146. *Id.* at 255. Fieldworkers have documented the difficulty of enforcement at both the richest and poorest extremes of society: rich people are able to pay fines assessed for second and third births; and poor people, especially migrant laborers, are difficult to track. *Id.* at 245. In addition, official dedication to the Policy has fluctuated over time. White, *supra* note 109, at 145, 147; *Fertility Policy in China*, *supra* note 117, at 245. After being strictly enforced, the Policy was relaxed to allow second births in limited circumstances. White, *supra* note 109, at 137, 149; CHINA'S SDI, *supra* note 11, at 133-139. The Chinese Government relaxed its Policy due to mounting difficulties in implementation, especially in rural areas. *Id.* at 134. See, e.g., Birth Planning Regulations, *supra* note 117, art. 3, 9 POP DEV. REV. at 555 (detailing exceptions to the One-Child Family Policy). In Shanxi, exceptions are made in cases that exhibit "special circumstances" or "real difficulties." *Id.* Situations characterized by "special circumstances" include:

1. The first child is declared deformed [and]. . . will not grow up as a normal labourer
2. One party of a remarried couple has a child from the previous marriage and the other does not.
3. Couples who have been sterile for many years after marriage and have adopted a child, provided that the women is 30 years of age or older.
4. Both parties of a couple are minority nationalities.
5. Both parties of a couple are returned overseas Chinese.

Id. Situations characterized as "real difficulties" includes:

1. After marriage, the husband settles in with the family of an only daughter.
2. People who have long been living in sparsely populated mountain villages not blessed with adequate traffic facilities and favourable natural conditions.
3. Only one of three brothers or more is fertile.
4. The only son of a martyr.
5. One party of a couple has a first degree deformity.
6. Families which have only one son for three generations in a row.
7. Both parties of a couple are an only son and an only daughter.

Id. Only couples living in rural areas may apply for approval for a second child based on "real difficulties." *Id.*

147. See CHINA'S SDI, *supra* note 11, at 132-33 (discussing "only child" certificates

cash bonuses, longer maternity leave, improved housing opportunities, or more farmland if they in fact limit themselves to one child.¹⁴⁸

In addition, "only children" receive adult food rations and priority status in education and employment.¹⁴⁹ Medical care

by which couples pledge to have one child); *Fertility Policy in China*, *supra* note 117, at 261 (referring to "only child" certificates). By June 1981, approximately three years after the announcement of the Policy, eleven million or 57 percent of Chinese couples had reportedly pledged to stop having children after their first, by accepting only child certificates. JACOBSEN, *supra* note 122, at 28.

148. JACOBSEN, *supra* note 122, at 28; David, *supra* note 53, at 163. Bonuses may equal up to an additional month's wage annually until the child reaches fourteen years of age. JACOBSEN, *supra* note 122, at 28. Some provinces provide for one-time cash bonuses and instead of cash bonuses, rural couples receive extra work points. *Id.*; see, e.g., Birth Planning Regulations, *supra* note 117, arts. 4, 6, 9 POP. DEV. REV. at 555, 556 (providing rewards to couples in Shanxi Province who limit themselves to one child).

If effective birth control measures are taken and the couple concerned receives a "one-child certificate", the woman can have maternity leave of from four to six months. Couples who are cadres, staff and workers are paid as usual during their marriage and maternity leave. Their absence shall not affect their attendance records, performance evaluations, bonuses, wage adjustments or promotions. Couples who are rural or commune members shall be given work points or equivalent amounts of money or grain as usual by the production team to which they belong.

Id. art. 4, 9 POP. DEV. REV. at 555.

Couples who have received "one-child certificates" are entitled to the following benefits:

1. From the month they receive a "one-child certificate", couples of state cadres, staff members, workers and urban residents are given monthly health subsidies of five yuan until the child is 14 years of age.
2. Depending on which form of the production responsibility system their production team practices, couples that are members of rural communes shall be given five work points or the cash equivalent every month by the production team as health subsidies for only children. Other reward methods such as lowering assigned output quotas may be adopted.

Id. art. 6, 9 POP. DEV. REV. at 556.

149. JACOBSEN, *supra* note 122, at 28; David *supra* note 53, at 163; see, e.g., Birth Planning Regulations, *supra* note 117, art. 6, 9 POP. DEV. REV. at 556 (providing benefits to only children in Shanxi Province).

3. Only children shall be given priority in being admitted into nurseries or kindergartens. In localities where conditions permit, these children shall be admitted entirely or partially free of charge.

4. Other conditions being equal, only children shall be given priority in urban housing assignments and readjustments. In rural areas, priority shall be given to them in assigning residential areas.

5. Only children of rural commune members shall be given the basic adult grain ration.

6. Other conditions being equal, only children are given priority in being recruited as students or workers.

for only children is either free or heavily subsidized.¹⁵⁰ Couples or individuals who submit to sterilization after their first child are rewarded with cash sums or paid leave.¹⁵¹ When one-child couples retire, they are entitled to larger pensions than required under current labor protection laws.¹⁵²

Couples who disregard the OCF Policy, however, face penalties.¹⁵³ Fines levied for a couple's second or third pregnancy may be equivalent to three years of the couple's wages, requiring monthly installments for up to sixteen years.¹⁵⁴ Parents of second or third children may be subject to decreases in salary¹⁵⁵ and some may be fired from their jobs.¹⁵⁶ Second and third children lose their rights to free education and health care, as well

Birth Planning Regulations, *supra* note 117, art. 6, 9 POP. DEV. REV. at 556.

150. JACOBSEN, *supra* note 122, at 28. *See, e.g.*, Birth Planning Regulations, *supra* note 117, art. 6, 9 POP. DEV. REV. at 556 (providing benefits to only children in Shanxi Province). "Medical departments shall classify only children as key health care recipients and conduct health check-ups for them on a regular basis. When only children are sick, they shall be given priority in registration, examination and hospitalization." *Id.*

151. *See, e.g.*, Birth Planning Regulations, *supra* note 117, art. 13, 9 POP. DEV. REV. at 558-59 (providing guidance regarding birth control methods). "Cadres, staff and workers will be granted paid leave for sterilization operations as allowed by regulations. Rural commune members who take such leave will have their workpoints registered as usual or be paid with proper subsidies." *Id.*

152. JACOBSEN, *supra* note 122, at 28; David, *supra* note 53, at 163.

153. *See* AMNESTY INTERNATIONAL, *supra* note 107, at 23 (noting that couples who have children above quota are subject to sanctions).

154. Davin, *supra* note 107, at 116; JACOBSEN, *supra* note 122, at 28; *see, e.g.*, Birth Planning Regulations, *supra* note 117, art. 10, 9 POP. DEV. REV. at 557-58 (providing for 20 percent deduction from couple's annual income at second pregnancy and 30 percent deduction from couple's annual income at third pregnancy).

155. JACOBSEN, *supra* note 122, at 28; *see, e.g.*, Birth Planning Regulations, *supra* note 117, art. 10, 9 Pop. Dev. Rev. at 557-58 (providing for maternity leave without pay, 15 percent deduction per year from couple's combined annual income for first seven years of second child's life, and 10 percent deduction from couple's monthly wages for first 14 years of third child's life). When collected, the monies are paid into a welfare fund that provides benefits to one child families holding one-child certificates. JACOBSEN, *supra* note 122, at 28 (providing that "deducted wages and workpoints should be put into welfare and public funds accounts of competent units or communes and brigades and be used as subsidies for planned parenthood work. They should be used exclusively for that purpose.").

156. *Ying*, 1995 WL 143830, at *9-23. Petitioner Hu Shuye testified that her husband was fired from his construction job 10 years after the birth of her second child. *Id.* at *16. State employees may be dismissed or demoted after the birth of their second child. AMNESTY INTERNATIONAL, *supra* note 107, at 23; *see, e.g.*, Birth Planning Regulations, *supra* note 117, art. 11, 9 POP. DEV. REV. at 558 (providing that "contract workers, workers employed according to verbal agreements, temporary workers or recruited workers from rural areas . . . shall be dismissed" if couple gives birth to more than two children).

as food and clothing rations.¹⁵⁷ The family may lose housing opportunities,¹⁵⁸ their houses may be demolished,¹⁵⁹ and their business and personal property may be seized.¹⁶⁰ The OCF Policy is successful, at least in terms of population growth statistics, with decreases the birth rate and population growth rate of 45.4% and 55%, respectively, since the 1970's.¹⁶¹

B. *The United States: Aid to Families with Dependent Children*

In 1935, U.S. Congress established AFDC,¹⁶² a cooperative federal-state assistance program¹⁶³ that provides cash benefits to

157. Davin, *supra* note 107, at 116; JACOBSEN, *supra* note 122, at 28.

158. Davin, *supra* note 107, at 115; *see, e.g.*, Birth Planning Regulations, *supra* note 117, art. 11, 9 POP. DEV. REV. at 558 (providing that to "those who give birth to two or more children without approval, in urban areas no additional housing will be granted and in rural areas no additional land for house construction or additional private plots will be granted."). In rural areas, second and third children may be denied portions of land. JACOBSEN, *supra* note 122, at 28.

159. AMNESTY INTERNATIONAL, *supra* note 107, at 23.

160. *Ying*, 1995 WL 143830, at *9-23. Petitioner Dai Xiu Ying testified that "[w]hen officials discovered [her second] pregnancy, they forced her to undergo an abortion and fined her 5000 yuan. Because she was only able to pay half of the fine, officials seized her clothing store to satisfy the remainder of the claim." *Id.* at *9. Petitioner Qu Yun Lian testified that "[w]hen payment [of 2000 yuan fine for becoming pregnant with her second child] became overdue, the government refused to allow [her family] to cultivate the land they usually worked." *Id.* at *10. In addition, relatives may be held hostage until fines are paid. AMNESTY INTERNATIONAL, *supra* note 107, at 24.

161. *White Paper*, *supra* note 116, at 3.

162. Social Security Act, tit. 4 § 401, 49 Stat. 627 (1935) (current version at 42 U.S.C. §§ 601-17 (1988 & Supp. V 1993)). Aid to Families with Dependent Children is statutorily defined as "money payments with respect to a dependent child or dependent children, or, at the option of the State, a pregnant woman." 42 U.S.C. § 606 (a) (1988 & Supp. V 1993). As part of U.S. President Franklin D. Roosevelt's New Deal legislation, AFDC nationalized state-subsidized Mothers' Pension programs that had, since the early 1910's, provided financial assistance to poor women raising children on their own. LINDA GORDON, *PITIED BUT NOT ENTITLED: SINGLE MOTHERS AND THE HISTORY OF WELFARE 1890-1935* 37 (1994); MIMI ABRAMOVITZ, *REGULATING THE LIVES OF WOMEN: SOCIAL WELFARE POLICY FROM COLONIAL TIMES TO THE PRESENT* 313-19 (1988); Gwendolyn Mink, *Welfare Reform in Historical Perspective*, 26 CONN. L. REV. 879, 880 (1994); Irene Lurie, *Major Changes in the Structure of the AFDC Program Since 1935*, 59 CORNELL L. REV. 825, 826 (1974).

163. *See, e.g.*, Ariz. Rev. Stat. Ann §§ 46-291 to -295 (1988 & Supp. 1995) (establishing Aid to Dependent Children in Arizona); CAL. WEL. & INST. CODE §§ 11200-514 (Deering 1991 & Supp. 1996) (establishing Aid to Families with Dependent Children in California); GA. CODE ANN. §§ 49-4-100 to -119 (1994 & Supp. 1995) (establishing Aid to Families with Dependent Children in Georgia); N.Y. SOC. SERV. LAW §§ 343-62 (McKinney 1992 & Supp. 1996) (establishing Aid to Dependent Children in New York); N.J. STAT. ANN. §§ 44-10-1 to -33 (West 1993 & Supp. 1995) (providing assistance for dependent children).

needy families.¹⁶⁴ The stated purpose of AFDC is to strengthen the family, encourage families to care for children in their own homes, and help parents attain self-sufficiency.¹⁶⁵ AFDC also functions as an implicit population policy to the extent that AFDC legislation attempts to affect reproductive behavior.¹⁶⁶

Initially, statistics attempted to affect the reproductive behavior of recipients by conditioning receipt of benefits on compliance with behavioral standards, including sexual abstinence.¹⁶⁷ For example, states denied benefits to illegitimate

164. 42 U.S.C. § 602(a)(7) (1988 & Supp. V 1993). "To determine eligibility, each state sets as a 'standard of need' an 'amount deemed necessary by the State to maintain a hypothetical family at a subsistence level.'" *C.K. v. Shalala*, 883 F. Supp. 991 (D.N.J. 1995) (quoting *Shea v. Vialpando*, 416 U.S. 251 (1974)). Under current law, families with resources of over US\$1000 are ineligible for benefits. 42 U.S.C. § 602(a)(7). In order to determine an individual family's need, a state considers the income and resources of all family members within the AFDC filing unit. *Id.*; see, e.g., *Bowen v. Gilliard*, 483 U.S. 587, 594 (1987) (finding mandatory family filing unit constitutional). The AFDC mandatory filing unit includes all co-resident minor siblings and parents of AFDC recipients. 42 U.S.C. § 602(a)(38) (1988 & Supp. V 1993). The assumption underlying the mandatory filing unit is that family members who live together pool their resources and share expenses. See *Bowen*, 483 U.S. at 594. Under current law, the birth of additional children results in an addition of members to the filing unit and entitles the family to an increase in benefits. 42 U.S.C. § 602(a)(38) (1988 & Supp. V 1993).

165. 42 U.S.C. § 601 (1988 & Supp. V 1993). Specifically, the purpose of AFDC is to:

encourag[e] the care of dependent children in their own homes or in the homes of relatives by enabling each State to furnish financial assistance and rehabilitation and other services . . . to needy dependent children and the parents or relatives with whom they are living to help maintain and strengthen family life and to help such parents or relatives to attain or retain capability for the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection

Id.

166. See *supra* note 11 and accompanying text (defining AFDC as implicit population policy of United States). See also Marion Buckley, *Eliminating the Per-Child Allotment in the AFDC Program*, 13 *LAW & INEQ.* 169, 185 (1994) (noting historical use of AFDC as tool for behavior modification and discussing recent attempts by states to modify behavior in order to reduce teenage pregnancies and out-of-wedlock births to AFDC recipients); Mink, *supra* note 162, at 196 (discussing recent attempts by states to modify behavior in order to reduce adolescent pregnancies and illegitimate births to AFDC recipients).

167. See, e.g., *King v. Smith*, 392 U.S. 309, 321 (1968) (noting legislative history of Social Security Act of 1935 indicating that States may impose eligibility requirements that relate to moral character); Laurence C. Nolan, *The Unconstitutional Conditions Doctrine and Mandating Norplant for Women on Welfare Discourse*, 3 *AM. U. J. GENDER & L.* 15, 19 (1994) (discussing eligibility requirements based on sexual behavior of mother). "Using vaguely defined rules, state welfare departments denied aid to single mothers who took in male boarders, who co-habited with men, who refused to identify the fathers of out-of-wedlock children, or whose homes and behaviors simply did not look

children¹⁶⁸ and to those children whose mothers had established relationships or taken up residences with men.¹⁶⁹ Following legal challenges to their constitutionality, States eliminated these requirements during the 1960's and 1970's.¹⁷⁰

Current law requires states to offer family planning services to AFDC recipients.¹⁷¹ States may not, however, mandate accept-

right to the investigators." ABRAMOVITZ, *supra* note 162, at 324. "Cohabitation" was understood to mean "essentially that the man and woman have 'frequent' or 'continuing' sexual relations." *King*, 392 U.S. at 314.

168. FRANCES FOX PIREN & RICHARD A. CLOWARD, *REGULATING THE POOR* 13 (2 ed. 1993); CHRISTOPHER JENCKS, *RETHINKING SOCIAL POLICY* 2 (1992); Lurie, *supra* note 162, at 831. Provisions denying AFDC benefits to families with illegitimate children were commonly known as "suitable home" provisions. *Id.* During the 1950's, at least 18 states attempted to pass legislation eliminating benefits for illegitimate children. WINIFED BELL, *AID TO DEPENDENT CHILDREN*, 73-74 (1965). In addition, women with illegitimate children were routinely denied benefits under most states Mothers' Pension programs. ABRAMOVITZ, *supra* note 162, at 201. Such provisions were thought necessary in order to secure a proper upbringing for children. *King*, 392 U.S. at 325.

169. PIVEN & CLOWARD, *supra* note 168, at 138-45. Provisions denying AFDC benefits to children whose mothers had established relationships or took up residences with men were known as "substitute father" or "man-in-the-house" rules. *Id.*; Lurie, *supra* note 162, at 831-32; Williams, *supra* note 11, at 723-24. For example, Alabama outlined three situations where a man would be considered a substitute father: (1) if he lived with the mother; (2) if he frequented the home for the purpose of cohabiting with the mother; or (3) if he cohabited with the mother outside of her home. *See King*, 392 U.S. at 313-14 (discussing Alabama's "substitute father" regulation). Benefits were denied under the theory that such children were no longer dependent because they did not suffer the absence of a parent. Lurie, *supra* note 162, at 832. In addition, Alabama defended such provisions by arguing that it discouraged illicit sexual relationships and illegitimate births. *King*, 392 U.S. at 318 (rejecting state's defense as illegitimate justification for AFDC disqualification).

170. *See, e.g.*, *New Jersey Welfare Rights Organ. v. Cahill*, 411 U.S. 619 (1973) (overturning New Jersey's "suitable home" provision that limited benefits to families with two legally married parents because it discriminated against illegitimate children) *Lewis v. Martin*, 397 U.S. 552 (1970) (striking California regulation that considered income of man who shared mother's home but who had no obligation to support child as factor for income qualification because man was not parent within meaning of Social Security Act); *King*, 392 U.S. at 325 (invalidating Alabama's "substitute father" provision because definition of man as parent was inconsistent with Social Security Act and because provision discriminated against illegitimate children); *see also Levy v. Louisiana*, 391 U.S. 68 (1968) (barring discrimination against illegitimate children).

171. 42 U.S.C. § 602 (a)(15) (1988 & Supp. V 1993).

A State plan for aid and services to needy families with children must . . . provide for the development of a program . . . for preventing and reducing the incidence of births out of wedlock and otherwise strengthening family life, and for implementing such program by assuring that in all appropriate cases (including minors who can be considered to be sexually active) family planning services are offered to them and are provided promptly to all individuals voluntarily requesting such services

Id.; *see, e.g.*, ME. REV. STAT. ANN. tit. 22, § 3741-L (West 1994) (establishing state-subsidi-

ance of family planning services as a prerequisite to receiving aid.¹⁷² Prior to the incorporation of the explicit requirement that women not be forced to accept family planning services as a prerequisite to receiving aid,¹⁷³ an indefinite number of women were coerced into accepting sterilization under the threat that, if they chose not to undergo the operation, they would lose their AFDC benefits.¹⁷⁴ In the 1970's, approximately 100,000 to 150,000 poor women were sterilized annually with federal funds.¹⁷⁵

During the early 1990's, the Federal Drug Administration's

dized family planning program in Maine); N.Y. SOC. SERV. LAW § 131-e (Consol. 1995) (establishing state-subsidized family planning program in New York); OHIO REV. CODE ANN. § 5107.10 (Baldwin 1995) (establishing state-subsidized family planning program in Ohio). In addition, federal funding to a state is reduced if the state fails to offer family planning services to AFDC recipients. 42 U.S.C. § 603 (f)(1) (1988 & Supp. V 1993).

172. 42 U.S.C. § 602(a)(15) (1988 & Supp. V 1993). Specifically, the Act states that "acceptance of family planning services provided under the plan shall be voluntary on the part of such members and individuals and shall not be a prerequisite to eligibility for or the receipt of any other service under the plan." *Id.* AFDC recipients' access to particular forms of fertility regulation, especially abortion, however, is limited. *See* 42 U.S.C. § 300(a)(6) (1988 & Supp. V 1993) (prohibiting Medicaid funding to state-sponsored family planning programs if abortion is promoted as method of fertility regulation); *Rust v. Sullivan*, 500 U.S. 173 (1991) (finding constitutional federal provision that deny Medicaid funding to state-sponsored family planning programs).

173. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 114 S. Ct. 909 (1994). In addition to the explicit provision that benefits not be made contingent upon acceptance of family planning services, states may not unduly burden women's reproductive choices. *Casey*, 114 S. Ct. at 909.

174. *See Relf*, 372 F. Supp. at 1201 (finding consent to sterilization involuntary when required for receipt of welfare benefits). "In short, federally assisted family planning sterilizations are permissible only with the voluntary, knowing and uncoerced consent of individuals competent to give such consent." *Relf*, 372 F. Supp. at 1201; *see generally* Charlotte Rutherford, *Reproductive Freedoms and African American Women*, 4 *YALE J.L. & FEMINISM* 255 (1992) (discussing sterilization of minority women on welfare during 1970's).

[P]ublic assistance officials tricked illiterate black welfare recipients into consenting to the sterilization of their teenage daughters. Native American women under twenty-one were subjected to radical hysterectomies and informed consent procedures were ignored. Doctors agreed to deliver the babies of Black Medicaid patients on the condition that the women be sterilized. Doctors have also conditioned the performance of abortions on "consent" to sterilization.

Id. A call for sterilization of AFDC recipients was made most recently in 1992 when a Washington State lawmaker proposed offering cash bonuses to poor mothers who submit to sterilization. Jim Simon, *Heavy Hand of Welfare Reform — Legislators Planning to Get Tough*, *SEATTLE TIMES*, Jan. 31, 1992, at B1.

175. *See Relf*, 372 F. Supp. at 1199 (discussing sterilizations of low-income persons under federally funded programs during the 1970's).

approval of a newly-developed long-term contraceptive method called the Norplant (R) System¹⁷⁶ ("Norplant"), prompted several state lawmakers to propose financial incentives to encourage AFDC recipients to use Norplant.¹⁷⁷ These proposals met with great resistance and none were enacted.¹⁷⁸ Furthermore, throughout the early 1990's, many states sought approval from

176. OUR BODIES, OURSELVES, *supra* note 138, at 288-92. The Food and Drug Administration approved the Norplant (R) System ("Norplant") in 1990. Philip J. Hiltz, *U.S. Approves Contraceptives Planted in Skin*, N.Y. TIMES, Dec. 11, 1990, at A1. Norplant consists of six match-stick size silicone rubber capsules inserted under the skin of a woman's upper arm. OUR BODIES, OURSELVES, *supra* note 138, at 288. The insertion and removal procedures must be performed by trained health care providers. *Id.* The synthetic hormone, levonorgestrel, is slowly released at low doses and provides continuous, reversible fertility control for up to five years. *Id.* Side effects include menstrual disorders and excessive bleeding. *Id.* at 289-90. Because of potential risks, Norplant cannot be prescribed for women with diabetes, hypertension, cardiovascular disease, thrombotic disease, acute liver dysfunction, or breast cancer. *Id.* at 290.

177. Mink, *supra* note 162, at 894-95 (describing proposed legislation that mandates or encourages use of Norplant by offering to women cash for implanting Norplant); *see, e.g.*, H.B. 1653, 18th Legis., 1995 Sess., 1995 Hawaii (proposing to offer women receiving AFDC \$50 per month for implanting Norplant); H.R. 1860, 97th Gen. Ass., 2d Sess., 1992 Tennessee (proposing to offer women receiving AFDC \$500 for implanting Norplant); *see also* Barbara Kantrowitz and Pat Wingert, *The Norplant Debate*, NEWSWEEK, Feb. 15, 1993, at 36 (reporting that according to the Alan Guttenmacher Insitute, "legislators in 13 states have proposed nearly two dozen bills that aim to use Norplant as an instrument of social policy"). Some proposals envisioned the availability of Norplant for poor women at no charge or at a greatly reduced rate. *See, e.g.*, Valerie Richardson, *California to Give Welfare Women the Latest Hormone Contraceptive*, WASH. TIMES, Feb. 22, 1992, at A1. By April 1992, all fifty states and the District of Columbia had approved Medicaid reimbursement for Norplant. *Norplant Gets Medicaid Okay in All 50 States*, UPI, Apr. 10, 1992, available in LEXIS, Nexis Library, UPI file.

178. *See, e.g.*, Linda M. Merritt, *Birth Control Incentives for Welfare Mothers*, 3 KAN. J.L. & PUB. POL'Y 171 (1993/1994) (discussing controversy regarding financial subsidy for implantation of Norplant); Tracy Ballard, *The Norplant Condition: One Step Forward or Two Steps Back?*, 16 HARV. WOMEN'S L.J. 139 (1993) (discussing controversy regarding loss of user control associated with Norplant); Steven S. Spitz, *The Norplant Debate: Birth Control or Woman Control?*, 25 COLUM. HUM. RTS. L. REV. 131 (1993) (discussing controversy regarding states' proposed Norplant legislation); Dorothy Roberts, *Norplant's Threat to Civil Liberties and Racial Justice*, N.J.L.J., July 26, 1993, at 20 (discussing controversy regarding government's alleged use of Norplant to restrict certain people from giving birth); Faye Wattleton, *Using Birth Control as Coercion*, L.A. TIMES, Jan. 12, 1991, at M7 (discussing editorial in *Philadelphia Inquirer* that suggested Norplant could be useful way to "reduce the underclass" linking population control to AFDC). *See* TENN. CODE ANN. § 71-5-133 (1995) (stating that "department of human services shall provide written information concerning the availability through the medicaid program of the Norplant contraceptive implant . . . to all aid to families with dependent children recipients when such persons apply for benefits"). In addition, the state of Hawaii has not taken final action on a bill proposed during the 1995 legislative session to encourage AFDC recipients to submit to Norplant implantation by offering an additional US\$50 per month. H.B. 1653, 18th Legis., 1995 Sess., 1995 Hawaii.

the Federal Government to institute AFDC reform experiments.¹⁷⁹ A popular reform measure among states has been to deny standard grant increases to children conceived and born to AFDC recipients.¹⁸⁰

States' reform efforts soon gained the attention of politicians calling for AFDC reform on a national level.¹⁸¹ Conse-

179. See Susan Bennett & Kathleen A. Sullivan, *Disentitling the Poor: Waivers and Welfare Reform*, 26 U. MICH. J.L. REF. 741, 741 (1993) (reporting that since January 1992 at least 30 states had requested waivers to initiate AFDC reform); Sam Howe Verhovek, *Welfare in Transition: The National Picture; States are Already Providing a Glimpse at Welfare Future*, N.Y. TIMES, Nov. 21, 1995, at 1 (reporting on AFDC reform plans instituted at state level during 1990's). The Secretary of the United States Department of Health and Human Services ("HHS") retains power to grant waivers from the requirements of the AFDC statute for any "experimental, pilot, or demonstration project[s]" that promote the objectives of the AFDC. 42 U.S.C. § 1315 (1988 & Supp. V 1993).

180. See WELFARE NEWS (Center on Social Welfare Policy and Laws, New York, N.Y.), Nov. 28, 1995, at 10 (reporting that 13 states have instituted "family cap" projects by which standard grant increases are denied to children conceived and born to AFDC recipients). See, e.g., N.J. STAT. ANN. § 44:10-3.5 (West 1993 & Supp. 1995) (eliminating increase in benefits for birth of additional child to AFDC recipients).

For example, a parent with one child can receive a grant up to \$322 a month in New Jersey. Under the federal system, if the mother had an additional child her grant would increase to \$424 a month. Under [New Jersey's AFDC reform system] she will not receive this \$102 increase. Similarly, a mother with two children would not receive the \$64 increase in her grant that she would otherwise receive if she had a third child.

C.K., 883 F. Supp. at 999-1000. The theory behind the "Family Cap" is that the denial of additional benefits encourages AFDC recipients to make responsible family planning decisions. See Melinda Henneberger, *Rethinking Welfare: Deterring New Births — A Special Report; State Aid Is Capped, But to What Effect?*, N.Y. TIMES, Apr. 11, 1995, at 1 (discussing controversy regarding effects of New Jersey's "Family Cap" provision). Notably, however, proponents measure the success of the "family cap" by tracking reductions in the birth rate among AFDC mothers. *Id.*; Marion Buckley, *Eliminating the Per-Child Allotment in the AFDC Program*, 13 LAW & INEQUALITY 169 (1994) (summarizing twin goals of "Family Cap" as to conserve state funds and to modify behavior among AFDC recipients); Williams, *supra* note 11, at 736-41 (discussing goals of "Family Cap"). Recently, a federal judge in New Jersey upheld the "Family Cap" against constitutional challenge because he found the provision rationally related to legitimate government purposes. C.K., 883 F. Supp. at 1012-15. The judge noted that the "Family Cap" promoted individual responsibility and strengthened and stabilized the family. *Id.* Moreover, the court rejected plaintiffs' argument that the "Family Cap" violated their fundamental rights to make private procreative choices because the court found that it did not unduly burden their procreative choices. Mink, *supra* note 161, at 197 (citations omitted). In addition, opponents argue that the "Family Cap" operates as if states had required AFDC recipients to accept family planning services as a prerequisite to receiving aid. *Id.* at 208.

181. See Robert Pear, *House Backs Bill Undoing Decades of Welfare Policy*, N.Y. TIMES, Mar. 25, 1995, at 1 [hereinafter *House Backs Bill*] (discussing U.S. President Clinton's campaign promise to "end welfare as we know it"); Maria L. Sachs, *The Prospects for Ending Welfare as We Know It*, 5 STAN. L. & POL'Y REV. 99, 99 (1994) (noting AFDC reform proposed during 1992 presidential election); see also James A. Krauskopf, *The*

quently, in March 1995, the U.S. House of Representatives passed House Resolution 4, an AFDC reform measure entitled the Personal Responsibility Act of 1995 ("PRA").¹⁸² In September, 1995, the U.S. Senate passed its version of House Resolution 4, entitled the Work Opportunity Act of 1995 ("WOA").¹⁸³ House Resolution 4 proposes to abolish AFDC and establish a system in its place that would provide for annual block grants to states that provide temporary assistance to the needy.¹⁸⁴

The new system envisioned by both versions of House Resolution 4 promises greater flexibility for states than that provided under current law.¹⁸⁵ Instead of requiring uniformity in program structure and standards of need, House Resolution 4 permits each state to design its own assistance program, as long as the program complies with certain minimum requirements.¹⁸⁶ For example, both versions of House Resolution 4 mandate that states focus on the prevention and reduction of teenage and out-of-wedlock pregnancies.¹⁸⁷

Administration of Public Assistance, 22 FORDHAM U. L.J. 883, 885-87 (1995) (providing background on welfare reform).

182. PRA, H.R. 4, 104th Cong., 1st Sess. (1995). See *House Backs Bill*, *supra* note 181, at 1 (reporting passage in U.S. House of Representatives by vote of 234-199, split largely along partisan lines).

183. WOA, H.R. 4, 104th Cong., 1st Sess. (1995). The House-Senate conference committee on the budget met for the first time on November 15, 1995 to work out a compromise on the differences between the House and Senate versions of the welfare reform bill. Robert Pear, *Battle Over the Budget: The Legislation; Republicans in Accord on Welfare Bill*, N.Y. TIMES, Nov. 15, 1995, at 10 (reporting agreement between House and Senate Republicans on comprehensive welfare bill). U.S. President Clinton has indicated that he will veto the compromise bill. *Id.*; Robert Pear, Alison Mitchell, *Clinton in Political Quandary on Welfare*, N.Y. TIMES, Nov. 20, 1995, at 9.

184. WOA, H.R. 4, 104th Cong., 1st Sess. § 101 (1995) (repealing AFDC, codified at 42 U.S.C. §§ 601-17) (proposed amendment to be codified at 42 U.S.C. §§ 400-499); PRA, H.R. 4, 104th Cong., 1st Sess. § 101 (1995) (repealing AFDC, codified at 42 U.S.C. §§ 601-17 except §§ 403(h) and 417) (proposed amendment to be codified at 42 U.S.C. §§ 401-499).

185. WOA, H.R. 4, 104th Cong., 1st Sess. § 101(b) (1995) (proposed codification at 42 U.S.C. §§ 401-02); PRA, H.R. 4, 104th Cong., 1st Sess. § 101 (1995) (proposed codification at 42 U.S.C. §§ 401-02); see *House Backs Bill*, *supra* note 181, at 1 (noting that AFDC reform proposals envision greater state control over assistance programs).

186. WOA, H.R. 4, 104th Cong., 1st Sess. § 101(b) (1995) (proposed codification at 42 U.S.C. §§ 401-02, 403 (b)(1)(A) (permitting states to use grant "in any manner that is reasonably calculated to accomplish the purpose of this part"); PRA, H.R. 4, 104th Cong., 1st Sess. § 101 (1995) (proposed codification at 42 U.S.C. §§ 401-02).

187. WOA, H.R. 4, 104th Cong., 1st Sess. § 101(b) (1995) (proposed codification at 42 U.S.C. §§ 401 (3), 402(a)(1)(F)); PRA, H.R. 4, 104th Cong., 1st Sess. § 101 (1995) (proposed codification at 42 U.S.C. §§ 401, 402(a)(1)(F)-(G)). The U.S. Congress suggests that punitive measures are the most effective way to accomplish reductions in the

More specifically, the PRA prohibits states from providing cash benefits to those children born out-of-wedlock to individuals under eighteen years of age.¹⁸⁸ The PRA also prohibits states from providing cash benefits to those children born to recipients who received benefits at any time during the ten-month period ending with the birth of the child.¹⁸⁹ The WOA permits, but does not require that states to institute such provisions.¹⁹⁰ In addition, both versions of House Resolution 4 provide for a five or ten percent increase in block grant amounts to those states that reduce their illegitimacy ratios¹⁹¹ by one or two percentage

rates of illegitimacy and teenage pregnancies. *See, e.g.*, PRA, H.R. 4, 104th Cong., 1st Sess § 101 (1995) (proposed codification at 42 U.S.C. § 405 (a)(4)) (prohibiting State from providing cash benefits for illegitimate children); *id.* (proposed codification at 42 U.S.C. § 405 (a)(5)) (prohibiting State from providing cash benefits for additional children born to recipients). Other, less harsh programs, however, have proven to reduce the incidence of repeat pregnancies among teenagers. *See Prepared Statement, supra* note 112 (discussing Teenage Parent Health Care Program). The Teenage Parent Health Care Program ("Program"), instituted in the late 1980's, provided eighteen months of intensive health-focused counseling by trained medical social workers for mothers under age 17 and their infants. *Id.* The Program reduced the incidence of repeat pregnancies by 57 percent. *Id.*

188. PRA, H.R. 4, 104th Cong., 1st Sess § 101 (1995) (proposed codification at 42 U.S.C. § 405 (a)(4)) (prohibiting State from using "any part of grant to provide cash benefits for a child born out-of-wedlock to an individual who has not attained 18 years of age, or for the individual, until the individual attains such age" except with respect to child born as result of rape or incest).

189. *Id.* (proposed codification at 42 U.S.C. § 405 (a)(5)) (prohibiting State from using "any part of the grant to provide cash benefits for a minor child who is born to a recipient of benefits under the program operated under this part or a person who received such benefits at any time during the 10-month period ending with the birth of the child" with exceptions for children born as result of rape or incest); *see supra* note 180 and accompanying text (discussing institution of "Family Cap" provision at state level).

190. WOA, H.R. 4, 104th Cong., 1st Sess § 101(b) (1995) (proposed codification at 42 U.S.C. § 406 (b)) (providing for state option to deny assistance for "child born out-of-wedlock to an individual who has not attained 18 years of age, or for the individual, until the individual attains such age"); *id.* (proposed codification at 42 U.S.C. § 406 (c)) (providing for state option to deny assistance to minor child born to recipient who received benefits at any time during the 10-month period ending with birth of child). In addition, the WOA provides states with the option of requiring teenage parents to live in adult-supervised settings. *Id.* (proposed codification at 42 U.S.C. § 406(d)).

191. *Id.* (proposed codification at 42 U.S.C. 406(f)(3)); PRA, H.R. 4, 104th Cong., 1st Sess. § 101 (1995) (proposed codification at 42 U.S.C. § 403(b)(2)). The term "illegitimacy ratio" is statutorily defined by the WOA as the number of out-of-wedlock births divided by the number of births in a state during one fiscal year. WOA, H.R. 4, 104th Cong., 1st Sess. § 101 (1995) (proposed codification at 42 U.S.C. 406(f)(3)). The PRA defines "illegitimacy ratio" to include, in addition to the number of out-of-wedlock births per fiscal year, the amount, if any, by which the number of abortions performed in a state during its current fiscal year exceeds the number of abortions performed

points, respectively.¹⁹² Both versions of House Bill 4 function as implicit population policies to the extent that they attempt to influence reproductive behavior in order to strengthen the family, reduce poverty, and prevent illegitimacy and teenage pregnancy.¹⁹³ While it is too soon to determine the effects of states' reform on the rate of births to teenagers and AFDC recipients, a recent study published by the U.S. Department of Health and Human Services predicts that federal reform, if implemented, will leave millions of American children impoverished.¹⁹⁴

III. THE POPULATION POLICIES OF CHINA AND THE UNITED STATES VIOLATE WOMEN'S RIGHT TO INFORMED CHOICE

As participants in the Cairo Conference, China and the United States pledged to ensure that their population policies respect women's rights to informed choice.¹⁹⁵ Commensurate with their pledges, China and the United States must ensure that their population policies respect women's right to make voluntary decisions regarding childbearing and fertility regulation.¹⁹⁶ Both China and the United States assert that their population policies permit voluntary reproductive choice.¹⁹⁷ Specific elements of both policies, however, preclude voluntary decision-

during the immediately preceding fiscal year. PRA, H.R. 4, 104th Cong., 1st Sess. § 101 (1995) (proposed codification at 42 U.S.C. § 403(b)(2)). In this way, the PRA encourages states to reduce abortions as well as out-of-wedlock pregnancies. *Id.*

192. WOA, H.R. 4, 104th Cong., 1st Sess. § 101(b) (1995) (proposed codification at 42 U.S.C. § 406 (f)) (providing for grant increase to reward states that reduce out-of-wedlock births); PRA, H.R. 4, 104th Cong., 1st Sess. § 101 (1995) (proposed codification at 42 U.S.C. § 403 (a)(1)(B)) (allowing for grant increase to states that reduce abortions and illegitimate births).

193. WOA, H.R. 4, 104th Cong., 1st Sess. § 101(b) (1995) (proposed codification at 42 U.S.C. § 401); PRA, H.R. 4, 104th Cong., 1st Sess. § 101 (1995) (proposed codification at 42 U.S.C. § 401).

194. DEPT. HEALTH AND HUMAN SERVICES, COMPARISON OF HOUSE AND SENATE WELFARE REFORM PLANS PASSED BY THE HOUSE MARCH 24, 1995 AND SENATE SEPTEMBER 19, 1995: IMPACTS ON CHILDREN 1-5 (Nov. 1995) (reporting that at full implementation, 3.3 million children would be denied assistance under WOA); see Henneberger, *supra* note 180, at 1 (reporting that it is too soon to prove effects of family cap on birth rate).

195. See *supra* note 12 and accompanying text (discussing participation in ICPD).

196. See *supra* notes 13, 56-62 and accompanying text (defining informed choice to include requirement that states respect and ensure women's rights to make voluntary decisions regarding childbearing and fertility regulation).

197. See *supra* notes 139, 180 and accompanying text (discussing China's and United States' assertions that their respective policies allow for voluntary decisionmaking).

making. Women living in China and the United States will not enjoy the full dignity of their human rights to informed choice until China and the United States support comprehensive reproductive health care programs that ensure voluntary reproductive choice.

*A. Physical Force and Coercion Preclude Voluntary
Reproductive Choice*

Partly as a function of its bureaucratic structure, China's Central Government relies heavily on local cadres to enforce its OCF Policy.¹⁹⁸ The Central Government issues directives and quotas to guide local enforcement.¹⁹⁹ In addition, the Central Government measures a cadre's performance by its region's overall fertility levels.²⁰⁰

In an effort to meet the expectations of the Central Government, cadres wield great power over women's reproductive lives. Women's reproductive cycles are tracked, and, when a woman becomes pregnant without official approval, family planning officials or community members meet with the woman to persuade her to obtain an abortion.²⁰¹ When persuasion fails, officials will often physically force the woman to obtain an abortion.²⁰²

The requirement that women submit to abortion, IUD insertion, or sterilization leaves no room for individual choice. Especially when physical force is threatened, women do not have the freedom to accept or refuse suggested methods of fertility regulation in favor of other, more appropriate methods, or in favor of no method at all.

China publicly condemns the use of physical force and coercion, but does not support these condemnations with appropriate sanctions.²⁰³ Thus, by its inaction, China permits the continued use of physical force and coercion to obtain compliance

198. See *supra* note 146 and accompanying text (discussing implementation of One-Child Family Policy at local level).

199. See *supra* note 117 and accompanying text (discussing One-Child Family Policy at central and local levels).

200. See *supra* note 136 and accompanying text (describing target management responsibility systems by which cadres are judged according to fertility levels in region).

201. See *supra* notes 138-43 and accompanying text (discussing provision of family planning services to women in China).

202. See *supra* note 142 and accompanying text (stating that Chinese women are forced to undergo abortion if necessary).

203. See *supra* note 139 and accompanying text (describing lack of adequate sanc-

with the OCF Policy. Consequently, China's conduct violates its Cairo conference pledge to respect and ensure women's rights to make voluntary decisions regarding childbearing and fertility regulation.

B. Incentives Offered to Individuals and Couples Preclude Voluntary Reproductive Choice

Chinese provinces offer incentives such as yearly cash bonuses, longer maternity leave, improved housing opportunities, and larger pensions to couples who limit themselves to one child.²⁰⁴ Chinese provinces also offer cash sums or paid leave to individuals who submit to sterilization after the birth of their first child.²⁰⁵ In addition, only children receive increased food rations and priority status in health services, education and employment.²⁰⁶ The use of incentives is justified by the view that, in light of the traditional Maoist emphasis on large families, couples will not limit family size unless materially encouraged.²⁰⁷

During the 1990's, several states in the United States proposed offering cash incentives to encourage AFDC recipients to use Norplant.²⁰⁸ In addition, all fifty States and the District of Columbia reimburse AFDC recipients for expenses connected with the insertion and removal of Norplant.²⁰⁹

Individual preferences regarding reproductive choices are shaped by a myriad of influences, including economic constraints, religious and cultural norms, as well as the wishes of partners and elders.²¹⁰ Absent evidence of physical force or co-

tions imposed by Chinese Government on officials who use force to obtain compliance with One-Child Family Policy).

204. See *supra* notes 148-52 and accompanying text (discussing incentives offered to couples who limit themselves to one child).

205. See *supra* note 151 and accompanying text (stating that couples receive cash or paid leave for undergoing sterilization).

206. See *supra* notes 149-50 and accompanying text (discussing benefits conferred upon only children in China).

207. See *supra* notes 127, 144 and accompanying text (describing traditional Maoist view on population growth and summarizing argument that couples will not voluntarily limit family size).

208. See *supra* notes 176-78 and accompanying text (discussing cash incentives proposed by U.S. state lawmakers to encourage AFDC recipients to use Norplant).

209. See *supra* note 177 and accompanying text (summarizing Medicaid reimbursement available for AFDC recipients who submit to Norplant implantation).

210. See DIXON-MUELLER, *supra* note 3, at 113-15 (discussing women's rights to make free reproductive choices).

ercion, the determination of whether a woman has made a voluntary choice regarding childbearing or fertility regulation thus becomes difficult.²¹¹ Incentives such as small cash sums, paid leave for sterilizations, or reimbursement for expenses facilitate choice, but only to the extent that they provide opportunities that, due to financial constraints, might not otherwise exist.²¹²

Incentives such as large cash sums, increased pensions, and improved housing, educational and employment opportunities are more substantial, especially in relation to many women's financial and social status.²¹³ Consequently, many women may see no reasonable alternative but to comply with the reproductive behavior required in order to obtain the rewards.²¹⁴ Under these circumstances, the decision to accept fertility regulation cannot be voluntary.²¹⁵ To the extent that China and the United States condone the use of incentives that offer women no reasonable alternative but to accept fertility regulation, China and the United States fail to ensure women's rights to informed choice.

C. *Disincentives Preclude Voluntary Reproductive Choices*

In China, couples who disregard the OCF Policy face severe

The idea of a right to decide freely on the number and timing of children poses a conceptual challenge. Because surveys inquiring about a person's reproductive wishes or intentions tap into individual preferences that have been shaped by group norms, economic constraints, and the influence of partners or elders, it is almost impossible to know whether a woman is making a "free" decision.

....

The freedom to decide on childbearing can be roughly approximated by two measures: (1) the amount of individual variation in fertility preferences within social groups; and (2) childbearing outcomes that are consistent with these preferences.

Id. at 113-14.

211. *Id.*

212. See *supra* note 55 and accompanying text (discussing effects of incentives and disincentives on voluntariness).

213. See *supra* note 55 and accompanying text (summarizing effects of incentives and disincentives on voluntariness).

214. See *supra* note 62 and accompanying text (stating that poor people may have no reasonable alternative but to accept incentive and forego reproductive choice).

215. See *supra* notes 55, 62, 92-97 and accompanying text (discussing opportunities for voluntary choice when faced with incentives and suggesting voluntariness continuum).

penalties.²¹⁶ Couples may be required to pay fines equivalent to three years of their combined wages.²¹⁷ Couples may face up to thirty percent reductions in salary or they may be fired from their jobs.²¹⁸ Families may lose housing opportunities and second and third children may lose food and clothing rations as well as their rights to free education and health care.²¹⁹ Chinese provinces justify their use of disincentives by reference to the belief that couples will not limit family size unless encouraged.²²⁰

The U.S. Congress has proposed that states deny benefits to needy families when additional children are born or when a girl under eighteen years of age gives birth.²²¹ Current reform efforts closely resemble lifestyle requirements imposed on recipients in the early 20th century, when benefits were conditioned upon the appropriateness of women's sexual behavior.²²²

By penalizing the exercise of choice, disincentives restrict individual choice to a greater extent than do incentives.²²³ By their reliance on disincentives, China and the United States violate their pledge to respect and ensure women's right to make voluntary decisions regarding childbearing and fertility regulation.

D. *Incentives Offered to the Community Preclude Voluntary Reproductive Choices*

The U.S. Congress has proposed that states receive an increase in block grants for temporary assistance to the needy when states achieve a one or two percent reduction in the

216. See *supra* notes 153-60 and accompanying text (describing sanctions suffered by couples who do not comply with One-Child Family Policy).

217. See *supra* note 154 and accompanying text (stating that couples may be fined for failure to comply with One-Child Family Policy).

218. See *supra* notes 155-56 and accompanying text (summarizing reductions in salary for non-compliance with One-Child Family Policy).

219. See *supra* notes 157-60 and accompanying text (summarizing sanctions suffered by second and third children).

220. See *supra* note 144 and accompanying text (summarizing arguments made in favor of incentives and disincentives).

221. See *supra* notes 188-90 and accompanying text (summarizing U.S. Congressional proposals regarding AFDC reform).

222. See *supra* notes 167-69 and accompanying text (describing measures by which states denied benefits).

223. See *supra* note 55 and accompanying text (discussing effect of disincentives on voluntary choice).

number of illegitimate births per year.²²⁴ Community-based financial incentives threaten voluntary choice because they encourage peer pressure.²²⁵ House Resolution 4 does not contemplate peer pressure among AFDC recipients, but, instead, seeks to encourage state legislatures to be more aggressive in their development of plans to reduce illegitimacy.²²⁶ If states implement plans similar to current AFDC experiments, whereby states deny standard grant increases to children conceived and born to AFDC recipients, then the community-based financial incentives will negatively impact women's reproductive choices.

E. Suggested Policy Alternatives That Support Women's Rights to Informed Choice

China and the United States must abolish the elements of their population policies that preclude voluntary reproductive choice. Instead of relying on punitive measures, China and the United States should support comprehensive health care programs that encourage responsible decision-making regarding childbearing and fertility regulation. Properly designed, high-quality health care programs ensure improvements in women's health and are accompanied by declines in overall fertility levels.²²⁷

The Cairo Programme outlines a framework for the design of high-quality health care programs.²²⁸ At the very least, women

224. See *supra* notes 191-92 and accompanying text (noting increase in block grants to states for reductions in illegitimacy ratio).

225. See *supra* note 55 and accompanying text (summarizing effects of community incentives on voluntary choice).

226. See *supra* notes 191-92 and accompanying text (discussing proposed increase in block grants to states for reductions in illegitimacy ratio).

227. See *supra* note 46 and accompanying text (discussing effect of improved health care services on overall fertility levels).

228. See *supra* note 51 and accompanying text (discussing elements of high-quality health care programs). "[C]hoice is not only the first, but the fundamental element of providing quality in services." Bruce, *supra* note 51, at 68.

It is by now a central principle of family planning programs that a choice of methods should be provided. Providing a choice does not necessarily mean that every program must provide all methods, but the overall program effort on a geographic basis should be sufficient so that prospective users have reasonable if not utterly equal access to a variety of methods.

Id. at 65.

Having a choice of methods is both a practical and philosophical commitment to respond to the user's needs. Practically, providers must carefully plan how to provide alternative technologies to clients. Philosophically, the availability

must be provided with a choice of family planning methods. Moreover, women must receive accurate, complete, and unbiased information regarding the risks, benefits, and side effects associated with each available method. Most importantly, high-quality healthcare programs can not coexist with incentive or disincentive schemes, because women must have the opportunity to make voluntary reproductive choices.

CONCLUSION

The population policies of China and the United States violate women's right to informed choice. Both policies rely on incentives and disincentives that preclude voluntary decision-making regarding childbearing and fertility regulation. China and the United States must support high-quality health-care programs that respect women's reproductive choices. Until then, women living in China and the United States will be denied the full dignity of their right to informed choice.

of multiple methods reaffirms the program's goal of service to the individual's need for effective contraception, not the promotion of a given method.

Id. at 66.