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and gender identity minorities, and women who are forced to migrate. Stigma leads to under-reporting across legal contexts, including via medical misclassification. Data on abortion incidence in low-income and middle-income countries are even more scarce than in those populations already mentioned, with the most severe gaps related to unsafe abortion.

By increasing the incidence of unsafe abortion—while simultaneously decreasing discourse, reducing access to sexual and reproductive health care, and disassembling health systems—the Protecting Life in Global Health Assistance policy makes a dire public health situation worse. The public health community should urge the USA to repeal the Global Gag Rule.

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Methodology in the GBD study of China

We found the Article by Maigeng Zhou and colleagues¹ intriguing. However, we have some concerns. Our major concern arises from mixing data from mainland China and Taiwan. These two regions have distinct health-care and social welfare systems; they also have different time trends of how socioeconomic conditions evolved during the past half century. Therefore, mixing the data from these two regions might lead to biased estimates, especially for the health outcomes shaped by health policies (eg, vaccination programmes as a prevention strategy).

Among all health issues, mental health is a particularly heterogeneous area between Taiwan and China. For example, the increasing suicide rate in Taiwan peaked in 2005,² whereas the suicide rate started to decline in China as early as 1990. Furthermore, the demographic risk factors associated with some mental health issues have been found to differ substantially between China and most developed countries, such as Taiwan. For example, the male-to-female ratio of alcoholism was 33:1 in China,³ whereas the corresponding ratio was 8:5 in Taiwan.⁴ Sex and alcoholism could jointly influence the susceptibility to several health outcomes, and therefore the difference in the sex ratio for alcoholism might lead to different disease burden estimates. Mixing such data from these two regions might therefore cause misinterpretations in associations between risk factors and outcomes due to ecological fallacy. This error might also complicate the assessment of an emerging disease, such as COVID-19. We believe that these concerns are worthy of being addressed.

We declare no competing interests.

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Maigeng Zhou and colleagues¹ claimed that they had implemented the same hierarchical model setup as Christopher Murray and colleagues had in their Global Burden of Disease Study (GBD),² in which Taiwan and China were treated at the same level in the hierarchical model. However, according to figures 3 and 4 in the Article,¹ Taiwan was placed at the level under the umbrella of China. The inconsistency between the methodology and results in these figures requires clarification.

The authors stated that, to ensure consistency, province-level estimates for the 32 provinces in mainland China were matched with the mainland's estimates, in which Hong Kong and Macau were not included. As Taiwan is not geographically located inside mainland China and has implemented a different data collection protocol, including Taiwan in the mainland's estimates is misleading.

The authors did not discuss different data collection protocols and procedures implemented in Taiwan and in China, which was discussed in a previous GBD Article by Murray and colleagues.² In addition, there is no acknowledgment for the original contributor of data on mortality and



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