Health Profile of Korean Women

Exploring the Socio-Cultural dimension of Women's Health

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Chapter 1
Introduction

Health is one of the fundamental rights of every human being. Equity and equality are at the heart of health security for women. Equal opportunities and the ability to benefit from the fruits of development, work in an safe environment, and live in a society free from violence are vital factors in shaping women's health today. However, the health security of women is at risk in many parts of the world.

When attempting to analyse the health of women, we should understand that it is influenced not only by biomedical factors but also by socio-cultural factors. The pervasive neglect of women, their inferior social, economic and cultural status, their exclusion from so many aspects of human development - education, access to resources, political power - and their specific biological needs and functions, have historically meant that women could not take good health as a given(WHO, 1995).

The following is a brief description of the socio-economic development of Korean society and how it is related to the health of Korean women.

Until the creation of the Republic of Korea in 1948, sexual discrimination against women dominated

all aspects of a woman's life due to the Confucian ideals at work in society. The Korean government has taken positive steps to enhance women's status on both the governmental and private levels. Noteworthy results have been: the revision of the *Labor Standards Act* in 1982; the ratification of the *Convention on the Elimination of All Forms of Discrimination Against Women* in 1984; and the foundation of the 'Korea Women's Development Institute' in 1983, which deals exclusively with women's issues on a national level. Moreover, the International Women's Year in 1975 and the subsequent UN Decade for Women (1976-1985) also brought about significant improvements in the status of Korean women, and the adoption of the above-mentioned policies greatly changed public attitude toward sexual equality and the concept of women's advancement in Korea.

The Women's Development Act was enacted in December, 1995. This law has historical meaning because it was made in a country where the status of women was very low, and it is a more comprehensive law compared with "Equal Status Act" or "Gender-Equality Acts", which focus only employment, found in other advanced countries. By integrating individual acts concerning women under this one, policies on women can be promoted consistently and systematically. Moreover, it includes an obligation to set up "*Women's Policies Development Planning*" every five years.

The Korean government recently decided to establish a foundation for the Women's Development Fund. By 1997, about $1.55 million will be secured in the Women's Development Fund, and this fund is expected to be up to $125 million by the year 2001. To ensure that this fund is used effectively, the government plans to form a committee for the use of Women's Development Fund. This fund will be utilized for social education for women, management of women's volunteer activities, women's international relationship cooperation program, and supporting women's organizations.

Along with the successful implementation of the 5-year economic development plans since the 1960's, much progress has been made in the social development of Korea. The impact of the social transition has been especially strong on Korean women, who have been assured an expanded role in society through changes in the traditional family structure, value system, and employment structure. In addition, the expansion of educational opportunities for women has contributed to developing women's capabilities and to raising their consciousness about gender-equality.

Development and changes in the economy and the society over the last 30 years have resulted in significant changes in the lifestyles of women. Some of these include: a longer life expectancy for women; a drop in the birth rate; an improved standard of

education; more nuclear families; changes in family life resulting from a raised level of consciousness; and less of a burden from household chores owing to the availability of electrical appliances. All of these factors have brought about a steady increase in the number of women engaging in various social activities and the number of those wishing to do so.

Nevertheless, the social status of Korean women is still low despite the socio-economic development of Korea, and gender inequalities are pervasive in Korean society. Furthermore, one of the most serious incidences of gender inequality is in the area of women's health, especially concerning the issue of reproductive health. The problems related to women's health have largely gone unnoticed in Korea because people are less conscious of the need for gender perspectives on health. Women have different body shape, organ size and volume, distribution of body fat, so that the bioavailability of therapeutic drugs differs between the sexes. As a result, health problems need to be analysed from the perspective of women. They suffer from diseases or conditions that affect men and women differently. However, few health policy decisions focusing on women can be found, and very little statistical information on the health of women is available in Korea.

Vulnerable health areas of women in Korea include a high induced abortion rate, adolescent reproductive

health problems, increased incidents of rape, maternal health problems, prenatal sex selection, increased rate of Cesarian Sections, increased rate of mental health problems, and lower utilization of health care facilities by women.

The factors affecting the health of Korean women are the low social status of Korean women, cultural attitudes concerning sex, such as the attitude toward purity and son preference, legal restrictions on induced abortions, insufficient measures to support and protect maternity and the lack of women holding high-level positions in health planning area.

Chapter 2
Demographic and Socio-economic Status

Demographic Indicators

Demographic transition has been very rapid in Korea. As a result of successful family planning programs, it has taken only several decades to achieve in Korea that which was accomplished over a 150-year period in European countries, namely going from high mortality and fertility to low mortality and fertility. Annual population growth rate was less than 1% in 1993. The total population of 44,453,000 in 1994 is expected be 50,590,000 in 2021, and the absolute number of the population will start decreasing after 2021 according to population projections.

More than 70% of the population lives in urban areas. The average number of children born per women in her lifetime was 1.75 in 1993, and no differences could be found in the average number of children when comparing urban and rural areas as a whole. The majority of deliveries take place between 25-29 years of age.

The total fertility rate has decreased rapidly ever

since the government adopted its population control policy in 1961 along with economic development. It dropped from 6.0 in 1960 to 1.75 in 1994. The decline for those in their twenties is mainly due to a rise in the age at marriage for women, while for those between 30-34 contraceptive use and induced abortion appear to be the most significant contributing factors(Cho et al, 1991).

Table 1. Demographic Indicators

Indicator	Data	Year
Population	44,851,000	
Male	22,576,000	1995
Female	22,275,000	
% of women in the total population	49.7	1995
% of population in rural areas	25.6	1990
Crude Birth rate(per 1,000 persons)	16.5	1994
Total Fertility rate	1.75	
Urban	1.75	1993
Rural	1.75	
Age-specific fertility rate (per 1,000 women)		
15-19 years old	3	1994
20-24 years old	7	
25-29 years old	195	
Crude death rate(per 1,000 persons)	5.5	1994
Natural increase rate (per 1,000 persons)	11.0	1994
Life expectancy at birth		
Male	69.5	1995
Female	76.6	
Mean age of first marriage		
Male	28.6	1990
Female	25.5	
Marriage rate		
Male	59.3	1990
Female	58.8	
Divorce rate		
Male	0.7	1990
Female	0.9	

Sources : NSO, *Social Indicators in Korea*, 1995.
KIHASA, *National Fertility & Family Health Survey Report*, 1994.

Table 2. Total Fertility Rates in Korea

Year	1960	1984	1987~1990	1993
Total Fertility Rate	6.0	2.1	1.6	1.75

Source: KIHASA, *1994 National Fertility and Family Health Survey*, 1994.

Socio-economic Indicators

Any sustainable improvement in women's well-being is inseparable from improvements in their social and economic status. This will be achieved by giving women greater power over their own lives, educating them, and providing opportunities for them to earn an income. The fact that women's wages on average were only slightly more than half(55.7%) the amount that men earn implies that there may be severe gender discrimination in the labor market. Women who represent half of the population occupy only 2% of seats in parliament(Table 3).

Korean residents aged 18~59 who are employed in firms with ten or more workers have been legally covered by National Pension Insurance since 1988. National Pension Insurance recipients numbered 5,444,818 in 1994(The National Pension Corporation, 1995). However, only 27.6% of them are women. While 16.8% of all Korean men are covered by National Pension Insurance, only 6.5% of Korean women are covered. In addition, the average salaries of women are lower than those of men.

Table 3. Socio-economic Indicators

Indicator	Data	Year
GNP per capita	$8,483	1994
Tertiary enrollments who are women	34.3%	1994
Female unemployment rate	1.9%	1994
Women's wage as % of men's wage	55.7%	1992
Paid employment who are women	38.5%	1993
Average hours worked by women[1)]	46.4 hour per week	1993
Administrative and managerial workers in government who are women	13.3%	1991
Seats in parliament occupied by women	2.0%	1995
Women physicians	17.7%	1994
Female heads of households	15.7%	1990

Note : 1) Average hours were computed, by putting weight on the class midpoint, multiplied by frequency.

Sources : NSO, *Social Indicators in Korea*, 1995.
__, *Annual Report on the Economically Active Population Survey*, 1992.
___, *Change of Employment Status During the Last 30 years: 1963-1993*, 1994.
____, *Population and Housing Census report*, 1992.
Han et al., *Study on the Elimination Measures to Discrimination against Women in Public Sector in Various Countries*, KWDI, 1993.
Chosun Daily Newspaper, Sep.19, 1995.
Ministry of Health and Social Affairs, *Yearbook of Health and Social Statistics*, 1995.

The two main reasons for women's low participation in National Pension Insurance are their low rate of participation in the labor force and their employment at firms not covered by National Pension Insurance. Many women are employed in small companies and

the service sector, or else they are self-employed.

The number of people receiving special old-age benefits is very limited. In 1993, 3.3% of Korean men and 0.5% of Korean women received special old-age benefits. Currently, only public employees, military personnel, and private school teachers are eligible to receive pension benefits. Others will be eligible for pension income in ten years. As a result, the Korean elderly tend to rely on their own personal savings rather than public pension.

Housewives are in a high economic risk group because most are not covered by National Pension Insurance under their own names. Although spouses of insured persons(those insured for at least one year) can receive survivor pensions, women whose husbands are covered by National Pension Insurance are few. Therefore few widowed women can receive survivor pension benefits.

As Koreans generally regard women as economically dependent on their husbands or children, discrimination against women in terms of salaries and employment opportunities is strong. Employed women and housewives alike are at high risk economically. This risk becomes even greater when they are widowed (KWDI, 1994; Statistical Yearbook on Women, 1994; The National Pension Corporation, National Pension Statistics, 1991～1994; Ko, KIHASA, 1992).

The figure shows that there is very little difference

in average educational attainment by gender for the young and middle aged generations and that most of them have at least a high school education(Table 4). Education is a crucial factor affecting the health of women. A woman who has access to education is better able to enhance not only her own health but also that of her family and community. Moreover, education allows women to obtain and use information, which is especially important in an environment continually creating new threats to health, as well as new opportunities to adopt healthy behaviors and life styles.

Table 4. Average Years of Educational Attainment by Sex & Age(1990)

(Unit: year)

	Average	6~19	20~29	30~39	40~49	50 and over
Total	9.54	7.74	12.03	11.09	9.52	5.53
Male	10.55	7.70	12.26	11.78	10.64	7.56
Female	8.58	7.79	11.81	10.37	8.35	3.92

Source: NSO, *Social Indicators in Korea*, 1994.

Social Status of Korean Women

Social Status of Women

The status of women in society has a direct impact on their health and the extent to which their lives may improve. The social status of Korean women is low when compared with the socio-economic

development of Korean society, and there are still many instances of gender discrimination.

Traditional Confucian culture had influenced the social status of women in Korea for a long time. Women have had few opportunities to obtain an education, good jobs or positions compared to the opportunities open to men in the society. Furthermore, women rarely get involved in the policy making process. This has resulted in male-oriented policies, and women's issues are hardly reflected in the policies. A low social status makes women financially dependent and vulnerable.

Cultural Attitudes toward Gender

A double standard toward sexual abstinence is built into the Confucian ideals. In the past, boys and girls were not supposed to sit together once they reached the age of seven. Despite this seemingly non-biased practice, the reality is that the strict moral and ethical norms of Confucianism, which are designed to tightly control society's moral standards concerning sex, have only been applied to females. Keeping one's virginity before marriage and practicing sexual abstinence were the two major virtues the society asked women not to violate. Moreover, girls are held responsible and made to feel ashamed for any violation of this strict moral code. This has resulted in a belief among young women that they

should hide any trace of sexual behavior and a general view among policy makers that problems like teen pregnancy are a personal problem. This attitude creates obstacles for making practical policies concerning adolescent reproductive health programs despite the fact that serious health and social problems, such as a high induced abortion rate among the unmarried, increasing number of unmarried mothers, and adoption, exist in society.

A preference for sons reflects the Korean tradition that only sons can continue the lineage of a family name and observe the rites for ancestor worship. This deeply rooted attitude leads to the practice of prenatal sex selection.

Influence of Gender Discrimination on Women's Social Activities

Confucian beliefs, including double standards, have influenced women's basic human rights, access to education and jobs, participation in policy making, and their health. According to the National Statistical Office(Chosun Daily Newspaper, 1995), the rate of Korean women's participation in policy making is much lower than in other nations. Korea was ranked the 90th out of 116 countries in terms of females' power in policy making.

The Korean government had endorsed women's right to vote in 1948, and became the 54th country

among 108 countries to give women the right to vote. However, the proportion of female members of congress was 2% in 1995, and this number is much less than that of advanced countries, which was greater than 30%(Chosun Daily Newspaper, 1995). The proportion of female ministers and female vice-ministers was 5% in 1995, which was less than that of European countries(7～9%).

Female high school graduates increased from 43,000 in 1965 to 330,000 in 1994. Women's rate of obtaining higher education was 34.3%, which is comparable to advanced countries. The proportion of women's participation in economic activities was increased from 37.2% in 1965 to 47.9% in 1994, while in advanced countries it is more than 50% these days. One problem among Korean working women is that they are economically active in their early 20s and 40s. This means that they do not continue to work shortly after they get married or have children, returning to work only after they have raised their children. The proportion of career women who are professionals, administrators, and managers in Korea was 9.6% in 1993, while advanced countries' proportion of career women was more than 30%.

Chapter 3
Health Status

Mortality and Morbidity

The leading causes of death in 1994 were malignant neoplasms, cerebrovascular diseases, and accidents. For females, cerebrovascular diseases were the first cause of deaths, and malignant neoplasm was the one for males(Table 5).

During the period two weeks prior to the Health Behavior Survey in 1995, the morbidity rate was about 345 per 1000 persons, indicating that the morbidity rate has increased since 1992(316 per 1000 persons in 1992). The chronic morbidity rate has increased while the acute morbidity rate has decreased(Table 6). The decreased morbidity rate is largely due to the advances in medical technology for preventing infectious diseases. Meanwhile, the increased chronic morbidity rate is due to lifestyle changes(e.g., decreased physical activity and unbalanced eating behaviors). The morbidity rate was higher among women than among men, and it increases with age. There seems to be a strong connection between low income and the high morbidity rate among elderly women.

Table 5. Ten Leading Causes of Death by Sex(1994)

Ranks	Male	Female
1st	Malignant Neoplasm	Cerebrovascular Disease
2nd	Accident	Malignant Neoplasm
3rd	Cerebrovascular Disease	Heart Disease
4th	Heart Disease	Accident
5th	Chronic Liver Disease	Hypertensive Disease
6th	Hypertensive Disease	Diabetes Mellitus
7th	Diabetes Mellitus	Asthma
8th	Tuberculosis	Chronic Liver Disease & Cirrhosis
9th	Suicide	Suicide
10th	Asthma	Pneumonia & Bronchitis

Source: NSO, *1994 Annual Report on the Cause of Death Statistics*, 1995.

According to the 1995 National Health Behavior Survey(Song, 1993), 15.9% of the persons surveyed perceived themselves as "not healthy"(urban 13.5%, rural 24.9%; male 10.6%, female 20.8%). Negatively perceived health status was found to be 14% in 1992 (urban 12%, rural 24%; male 12%, female 17%), and females were more likely than males to report that they are not healthy.

Table 6. Morbidity rates during two weeks before the Health behavior survey(1992-1995)

(Unit: per thousand persons)

	1992	1995
Total morbidity	316	345
(Acute morbidity)	(180)	(139)

Source: Choi, et al, *The level of Health and Medical Utilization Practice of the Korean People*, KIHASA, 1995.

The 1995 survey found that there was not any significant difference between urban and rural residents in use of medical facilities. Approximately half of those surveyed said they visit hospitals or clinics more than once a year(urban 52.5%, rural 51.7%).

The persons who had been ill during the two weeks prior to the survey accounted for 34.5% of all respondents. The average number of inactive days of these ill persons was 0.7 days(average number of sick days was 6.7 days), and the average bed days was 0.5 days. The estimated number of sick and inactive days in one year for an individual is 56 and 6 days respectively(estimated average bed days: 4 days). The average days of hospitalization was 17.8 days per hospitalized person and 16.8 days per hospitalized case.

The most prevalent types of cancer among women are cancer of the cervix(22.2% in 1992), stomach(17.5%), and breast(11.5%). Cancer of the stomach(28.0% in 1992), lung(16.0%), and liver(15.0%) were the most prevalent diseases among men(KPHA, 1995). Female adults were more likely than male adults to suffer from diabetes. According to a study of mental illness among those who are insured, women(28.5 per 1,000 persons) were more likely than men(28.5 per 1,000 persons) to have been treated for mental illnesses.

Generally women live longer than men. However, health expectancy throughout the lifespan of a woman is 49.9 years compared with 50.7 years for men. Health

expectancy represents the expected years during which one doesn't feel any discomfort or pain due to morbidities. The percent of health expectancy to life expectancy at birth is 75.9% for men and 66.69% for women. The proportion of years without any illness during the lifespan of women is 10% lower than that of men(Yoon, 1995)

Reproductive Health

Guaranteeing reproductive health implies that people are able to have a responsible, 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. Implicit in this last condition are the rights of men and women to be informed of and to have access to safe, effective, affordable, and acceptable methods of fertility regulation of their choice. In addition, it implies the right of access to appropriate health services that will enable women to go safely through pregnancy and childbirth and will provide couples with the best chance of having a healthy infant(WHO, 1994).

Therefore, attitudes towards reproductive health must be extended beyond obstetrics and gynecology. Women should have the ability to achieve autonomy and self-determination, to strengthen their position in society, and to assume control over their own bodies.

Cultural and Social Factors: Issues Related to the Sex Ratio and Son Preference

Normally, the sex ratio at birth should be around 106 males per 100 females. According to the National Statistical Office, the sex ratio at birth was 103.9 in 1980 and it rose to 115.4 in 1994. Furthermore, the sex ratio at birth increases according to the birth order(NBOS, 1st birth 106.4; 2nd birth 112.8; 3rd birth 195.7; 4th birth 232.4). This may be largely due to the strongly rooted tradition of son preference in the culture and the adoption of prenatal sex selection practices in Korea.

Confucian thought has dominated Korean society and serves as the basis for preferring sons to daughters(Ha, 1975). Son preference reflects the Korean tradition that only sons can continue the lineage of a family name and observe an ancestor worship rites. The increased preference for sons is causing increased numbers of sex selective abortions.

These days most couples want a small number of children; however, the couples want at least one son in their family. Again this is because of the traditional Confucian influence on Korean culture, which has resulted in the beliefs that only sons can carry on their family lineage.

Table 7. Changes in Sex Ratio at Birth by Birth Order, 1980-1994[1)]

Birth order	1980	1982	1984	1986	1988	1990	1992	1994
All births	103.9	106.8	108.3	111.8	113.4	116.8	114.0	115.4
First	106.1	105.4	106.1	107.3	107.4	108.7	106.4	106.1
Second	106.5	106.0	107.2	111.3	113.3	117.2	112.8	114.3
Third	106.3	109.2	116.9	138.7	166.3	191.9	195.6	205.6
Fourth & over	110.2	113.7	128.1	150.6	185.7	218.9	229.0	237.7

Note : 1) Sex ratio is a ratio of males per 100 females.
Source: NSO, *Annual Report on the Vital Statistics*, Various Years.

The use of fetal-screening technologies for sex identification was outlawed in 1987, and the medical code was further strengthened in 1994. However, sex selective abortions are still performed in Korea. The increasing sex ratio at birth by birth order means that legal restrictions alone are not effective when a preference for sons persists in society.

In spite of this longstanding son-preference attitude, prenatal sex-selection was not prevalent until the Total Fertility Rate reached the replacement level(2.1 child per married couple) in the middle of the 1980s. Fertility decline combined with son-preference and the availability of sonogram to detect sex of a fetus makes prenatal sex-selection possible.

Sex-selective induced abortions raises ethical issues regarding basic human rights and the potential health risk to women. The abnormally high sex ratio may increase the number of single males due to the

shortage of Korean brides, and this may cause an increase in sexual crimes in the future.

Today, Korean couples have only a few number of children, and they bring up their children without discrimination between sons and daughters. Girls face the real problem of finding a job after graduating from school. The opportunities of finding employment for women are very limited compared to men. To solve the problem of prenatal sex-selection, a restriction on the medical services is not enough. The alleviation of gender-inequalities in the society may be the most effective way of ending this practice.

Maternal Mortality

The maternal mortality rate was estimated to be 3.0 per 10,000 live births in 1991. However, because this figure was produced by relying on the maternal mortality rates which were themselves indirectly estimated in the early 1980s, it is difficult to say how reliable the rate for 1991 is. The maternal mortality rate seems to have decreased recently due to the national health insurance scheme and the fact that most deliveries are taking place at hospitals or clinics.

However, an internationally accepted rate has not been produced due to an incomplete vital registration system, and there is no other alternative way to measure it. Again, whether the causes of death displayed in Table 8 accurately represent the Korean

situation is doubtful, because the vital registration is incomplete. One of the weakest areas in health is the severe lack of accurate statistical data for even the most basic statistical information. According to the annual report on the cause of death statistics, the major causes of maternal mortality are puerperal complications and pregnancy intoxication(Table 8). Although there has been great progress in socio-economic and health-medical environment, a maternal health statistics production system has yet to be developed.

Table 8. Cause of Maternal Deaths(1991)

Cause of Death	Distribution(%)
Total	100.0
Abortion	7.4
Bleeding	22.2
Pregnancy intoxication	33.4
Obstructive delivery	1.2
Puerperal complications	35.8

Source : Park et al., *Direction of Maternal and Child Health Policy*, KIHASA, 1993.

Induced Abortion

Induced abortions are not in principle allowed under the *Maternal and Child Health Law* in Korea. However, pregnancies due to contraceptive failure have remained high and have also resulted in a high induced abortion rate despite the regulations in Korea. Induced abortion experience rate among married women was 49% in 1994, which had decreased from

54% in 1991(Kong, 1992; Hong, 1994).

This high rate can be traced to unwanted pregnancies among married women due to contraceptive failure and to prenatal sex selection because of the desire to have a son.

Table 9. Pregnancy Outcome by Residence

(Unit: %(number))

	Whole country	Urban	Rural
No of pregnancies	100.0(15,316)	100.0(12,384)	100.0(2,932)
Births	61.0	59.7	66.3
Stillbirths	0.4	0.3	0.6
Abortion	8.2	8.5	6.8
Induced abortion	28.3	29.2	24.6
Currently pregnant	2.1	2.2	1.6

Source: 1994 National Fertility & Family Health Survey.

Although few studies have been conducted on the rate of induced abortions among unmarried women, we think it deserves more attention. According to a study conducted in a medium-sized city in 1990, unmarried women accounted for 32.9% of all induced abortions performed(Hong, 1990). Considering the comparative conservativeness of this city, we estimate the actual number of induced abortions among the unmarried to be much higher. One of the reasons for this may be an increased sexual activity among youths and the unmarried.

Induced abortions are widely available but performed

secretly in Korea due to the legal restriction on them. This restriction imposes an economic burden on those who obtain these services, and safe medical practices can not be guaranteed.

Students and young workers receive sex education and counselling services, but family planning and contraceptive services have rarely been provided for them in our Confucian culture.

Abortion Legislation and Trends

The first institutional attempt to control the practice of induced abortion was *Criminal Act no. 293* concerning the crime of induced abortion enacted in September, 1953, which criminalized abortion. According to the Act, medical personnel providing such services and women accepting them could be imprisoned. In 1962, a family planning program was started as part of the population control policy. Some supported the enactment of a special law to relax the criteria for legally allowing some induced abortions. After much discussion and a public hearing, the *Maternal and Child Health Law* was enacted in May, 1973.

The law maintains that induced abortions are not allowed in principal, but are permitted in the following cases if the husband and wife agree and if they are performed within 28 weeks of conception:

1) Either parent has a hereditary, physical or

communicable disease;
2) Pregnancy as a result of rape;
3) Pregnancy as a result of incest;
4) Increased maternal health risk as a result of pregnancy.

The increased number of abortions among unmarried women may be related to the increasing preference for marriage at a later age, as well as the prevalence of sexually stimulating material and an attitude of free sex and hedonism. Legal regulations have also not curbed the easy accessibility to abortion services, as such services are obtainable nationwide.

Confucianism is based on secularism and rationalism, and if the discrimination against women is alleviated, the idea of son preference may be mitigated. In the Confucian dominated, agricultural society it was preferable to have as many children as possible. However, when people realized that having a small number of children is more beneficial for the lives of the family, they easily accepted the new idea. This kind of attitude is widespread in Korean society, where the fertility rate has decreased rapidly.

Parents no longer expect their son to take care of them later in their lives these days. Moreover, there is not much difference between male and female children in obtaining an education, either. However, women still face discriminatory practices when it comes to finding a job or getting promoted in the

society, and this makes it difficult to mitigate the son preference attitude in Korean society.

Cesarean Sections

The Cesarean-Section rate increased substantially within a very short period of time from 9.6% in 1986 to 28.1% of all deliveries done in 1993 in Korea (Table 10). The rate was high compared with other developed countries(Park, 1993), for example 10.1% in the U.K.('83) and 24.1% in the U.S.A.('86). The Cesarean-Section rate seems to be closely related to the payment system for medical services. This high rate may reflect the unreasonable medical insurance fee payment system in Korea. Appropriate policy measures should be devised to control the increase in the Cesarean-Section rate.

Table 10. Trends of Cesarean-Sections(1986~1993)

Year	C-Section Rate
1986	9.6
1987	11.3
1988	13.2
1989	14.8
1990	18.1
1991	20.3
1993	28.1

Source: Park et al., *Direction of Maternal and Child Health Policy*, KIHASA, 1993.

Adolescent Reproductive Health Problem

Adolescent fertility and sex-related problems have been an area of concern. There has been an alarming increase in sex-related problems, particularly unwanted pregnancies, abortion, and psychological problems among the youth. According to a sample survey, 78.1% of unmarried industrial male workers and 36.3% of university male students claimed to have had an experience of sexual intercourse(KIHASA, 1994). The proportion of sexually active teen-agers is not small. The study shows that 34.2% of teen-age industrial workers and 6.2% of the teen-age university students had had a sexual experience. This raises an issue concerning the prevention of HIV/AIDS and STD's because most of the sexually experienced respondents said that they had had sex with a prostitute (Industrial Worker: 80.0%, University Student: 72.8%). In spite of this serious situation, most of the Korean people, especially those who are in a position to make policy decisions, have conservative attitudes towards adolescent sex programmes.

Mental Health

The overall morbidity rate of mental illnesses is 2,703 per 100,000 people. The mental morbidity rate for women is 1.8 times higher than that for men. The

causes of mental illness for most female patients are related to affective disorders, while those of male patients are related to alcoholism and schizophrenia. This seems largely due to the gender difference in the use of mental health services.

Mental morbidity rates increase continuously with age from age 20 to 60. Mental morbidity rates reach their peak at age 50 to 60. Among those in their 50s, the mental morbidity rate for females is 9,271, while the rate for males is 3,942 per 100,000(KIHASA, 1994).

In 1995, the MOHW[1)] enacted the *Mental Health Law* to ensure that the human rights of mental patients are protected, to promote activities for the prevention of mental illness and to establish a comprehensive mental health system which would include the participation of central and local governments, communities, and the population at large.

Aging

According to a KIHASA survey(Rhee, 1994), 85.9% of the elderly aged 60 or over have chronic diseases (male 77.1%, female 91.7%), and 72.2% of them experience difficulty performing the activities of daily living(male 59.4%, female 80.6%). Chronic diseases were more prevalent among elderly women than elderly men(Table 11).

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1) The name of Ministry of Health and Social Affairs was changed into Ministry of Health and Welfare in 1995.

Table 11. Chronic Disease Morbidity Rates Among those 60 Years Old and Over in Urban and Rural Areas

(Unit: %)

	Urban	Rural
Total	83.4	89.2
Male	71.9	83.7
Female	90.7	92.9

Source: Rhee et al, *Study on Lifestyle of Korean Elderly and Policy Issues*, KIHASA, 1994.

In addition, elderly women were more likely than men to suffer from more than one chronic disease. This figure shows that the physical status of elderly women is much worse than that of elderly men (Table 12). The elderly comprise only 5.3% of the population covered by health insurance, but they account for 10.3% of all health insurance costs.

Table 12. Number of Chronic Diseases per Person by Sex (aged 60 and over)

(Unit: %)

	Total	Male	Female
None	14.1	22.9	8.3
1	27.3	31.9	24.2
2 and over	58.6	45.2	67.5
Total	100.0(2,058)	100.0(817)	100.0(1,241)

Source: Rhee et al., *Study on Lifestyle of Korean Elderly and Policy Issues*, KIHASA, 1994.

Nutrition

Discrimination in Food & Nutrient Allocation

Nutrition standards among the general population has improved considerably with Korea's socio-economic development. Emerging nutritional problems are obesity and unbalanced diet. These problems are related to quality and taste rather than quantity.

In most Korean families, meal choices are made based on the husband's preferences. When the elderly live with their children, especially elderly widowers, often the choice is made according to children's preferences. In wealthy families, priority to a restorative is usually given first to husbands, then children, then wives.

No studies have focused on gender differences in nutrition and related behavior in Korea. While there seems to be no saliently discriminating socio-economic practices, patriarchical culture in Korea has affected nutrient allocation practices. The culture of son preference affects nutritional status of female children. Discrimination in the feeding and care of female infants can be found in many countries in South Asia, the Middle East and parts of Africa(UN, Human Rights, 1995).

According to the WHO, malnutrition is the most widely spread and disabling health problem among women in developing countries. The malnutrition among

women is largely due to both poverty and the status of women. Both men and women are affected by nutritional factors, but women, for biological reasons, have a higher risk of suffering from health impairing nutritional deficiencies. Both women and girls need more iron than men because of menstruation, pregnancy, lactation and other physiological demands. Women with insufficient iron supply in their diet may suffer from anaemia, a condition that causes extreme fatigue and lower resistance to disease, as well as difficulties in pregnancy and childbirth(WHO, Women's Health, 1995).

Disabled Women

Estimated proportion of people with disabilities in Korea is 2.35% and 45.7% of them are women(Table 13), reflecting the fact that disability is more prevalent among males than females. However, disabled women were more likely than disabled men to feel unhealthy and suffer from chronic diseases. In addition, disabled women were less likely than disabled men to have someone care for them.

Disabled women are more likely than disabled men to suffer from unequal opportunities in the society. Disabled women were less likely than disabled men to get proper education, and this fact influences on their socioeconomic activities.

About 60% of the disabled people, excluding those

institutionalized, were suffering from financial difficulties, according to the 1995 Disabled People Survey (KIHASA, 1995). There was no gender difference in the feeling that one has financial difficulties. However, the rates of employment among the disabled were 43.5% for males and 18.2% for females. Employed disabled persons comprised 38.4% among the total disabled population surveyed, excluding students and housewives. They are employed mostly as agriculture and fishing industry workers(31.4%), laborers(23.0%), service and sales workers(17.9%), and skilled workers (14.8%). Males are more likely than females to be employed in professional and technical fields. Females are more likely than males to be labourers or employed in agriculture and fishing industry.

Table 13. Prevalence of Disability by Gender

Gender	Physically Disabled	Visually Impaired	Hearing Impairment	Speech Impairment	Mentally Retarded	Total
Male	56.4	45.6	45.9	59.2	58.0	54.3
Female	43.6	54.4	54.1	40.8	42.0	45.7
Total	100.0	100.0	100.0	100.0	100.0	100.0
(N)	2,257	237	497	118	226	3,335
Nationwide Estimation	696,249	73,104	153,444	36,371	69,669	1,028,837

Source: KIHASA, *1995 Disabled People Survey*.

Lifestyle Related Health

Smoking

There is a big gender difference in smoking behavior. This is because traditionally smoking cigarettes or cigars is considered to be a man's behavior. The proportion of current female smokers is about 5.6%, while that of current male smokers is about 61.0%. Although the proportion of female smokers is relatively small, the smoking rates among young women are increasing(Table 14). The smoking rate for women was 3.4% in 1992..

Table 14. Current Smokers by Gender 1995(age 20-59)

(Unit: %)

	Current Smokers
Total	32.2
Male	61.0
Female	5.6

Source: Nam et al., *Korean's Health Awareness and its Affect on their Behaviors*, KIHASA, 1995.

Drinking Alcohol

A national survey of Korean health behavior by KIHASA has shown that the overall rate of drinking among those 20 to 59 years of age has decreased from 49.3% in 1989 to 35.5% in 1995(Nam et al., 1995). The alcohol consumption rate was determined by the

percentage of those who responded positively to the question "Do you enjoy to drink alcohol beverage currently?" Among those aged 15 to 69 years, 31.4% reported drinking alcoholic beverages. Men(50.8%) were more likely than females(13.5%) to consume alcohol. About 24.8% of male drinkers and 7.7% of female drinkers reported that they drink alcoholic beverages daily(Table 15).

Table 15. Current alcohol consumption rate by gender and age[1)]

(Unit: %)

	Total	15~19	20~29	30~39	40~49	50~59	60~69
Male	50.8	14.1	54.4	58.8	60.1	51.6	45.1
Female	13.5	5.6	26.4	14.8	9.6	6.0	8.0
Total	31.4	9.6	39.4	36.5	35.2	27.9	23.8
(N)	(6,480)	(763)	(1,431)	(1,609)	(1,192)	(922)	(563)

Note : 1) Rate = No. of alcohol consumer No. of survey respondents × 100

Source: Nam et al., *Korean's Health Awareness and its Affect on their Behaviors*, KIHASA, 1995.

Women with HIV/AIDS

The first Korean HIV case was reported in December, 1985. By January, 1996, a total of 527 HIV cases had been reported(Table 16). Most of the HIV cases were males, and about 3/4 of the cases were in their 20s and 30s. The major route of transmission of HIV infection for Koreans had been sexual contact

with foreigners in the beginning. However, the major route of HIV transmission has been sexual contact among Koreans since 1992.

Table 16. Annual Prevalence of HIV Infection by Gender 1985~1996

Gender	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96. Jan.	Cumulative total
Male	1	1	4	17	35	50	38	72	71	78	89	3	459
Female	0	3	5	5	2	4	4	4	7	12	19	3	68
Total	1	4	9	22	37	54	42	76	78	90	108	6	527

Source: Kim, "Current Status of Care for HIV/AIDS Cases and Countermeasures in Korea", Seminar on AIDS Prevention and Control held by the Institute of Reproductive Medicine and Population, Seoul National University, 1996.

The first Korean AIDS patient was diagnosed in December, 1987, and this number excludes a foreign AIDS patient reported in Korea in June, 1985. By January, 1996, a total of 41 AIDS cases have been reported and 37 of them have died(Table 17).

Table 17. Annual Prevalence of AIDS Patients 1985-1996

Gender	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96. Jan.	Cumulative total
Male	0	0	1	2	0	2	0	2	5	10	14	0	36
Female	0	0	0	1	1	0	1	0	1	1	0	0	5
Total	0	0	1	3	1	2	1	2	6	11	14	0	41

Source: Kim, "Current Status of Care for HIV/AIDS Cases and Countermeasures in Korea", Seminar on AIDS Prevention and Control held by the Institute of Reproductive Medicine and Population, Seoul National University, 1996.

HIV/AIDS cases have not been many in Korea and social concern is relatively low. AIDS prevention and control policies in Korea are composed of three factors: the prevention and education program; screening of HIV cases; and the HIV control program. Our AIDS policy is primarily focusing on screening of HIV infection, but we do not have an adequate system to protect the public from AIDS patients. Health centers and public STD clinics provide free treatment services, and the treatment of AIDS by hospitals or clinics is covered by health insurance and the medical aid system. The government provides zidobudine(AZT) free of charge to all the persons with HIV/AIDS.

Education and counselling services are primarily provided to high risk groups. The National AIDS Committee(NAC) was formed in March, 1987. The Center for AIDS Control was established at the NIH in May, 1987, and the Center provides technical support for the national AIDS prevention program (NAP), especially in the area of laboratory testing, training and research. HIV testing of all the donated blood and plasma units started in July, 1987. We need to strengthen effective and adequate AIDS education programs for the public.

Support services for patients' families are insufficient. Only a few self-help groups for homosexuals exist. Some religious groups offer support and the government

makes small monetary contributions to the AIDS Union and AIDS Federation.

The Korean government should make every effort to cooperate with the AIDS policies made by the WHO Regional Office for the Western Pacific. In addition, any UNAIDS programs and initiatives for the prevention of AIDS should be applied to the Korean AIDS policy after careful review.

Preventive Health Behavior

The rates of undergoing a health examination for women have increased since 1989, but women are still less likely than men to have had a health examination(Table 18). The higher rate of receiving a health examination for men is largely due to the employee medical insurance in the National Medical Insurance system. Those employed have more chances to receive health examinations than those not employed, because the employed get the health examination at their workplace. Women are less likely than men to be employed, and thus it is more difficult for them to receive periodic health examinations.

Table 18. Proportion of Receiving Health Examination by Gender

(Unit: %)

	Total	15~19	20~29	30~39	40~49	50~59	60~69
Male	41.8	39.5	33.7	43.8	49.2	46.1	34.3
Female	30.9	39.3	30.3	25.4	35.9	30.8	26.2

Source: Nam et al., *Korean's Health Awareness and its Affect on their Behaviors*, KIHASA, 1995.

Health Consequences of Violence

Domestic Violence

Until now, Koreans have considered families to be harmonious and did not regard domestic violence as a public affair. However, several researchers have recently pointed out the seriousness of domestic violence and called public attention to this matter. There are no national statistics on the prevalence of domestic violence(wife-battering and child-beating), but some data are available from shelters and through criminal records. The figures will be lower than in actuality, as most cases of domestic violence are kept hidden.

Under current law, abusers committing serious battering are subject to *The Act of Violence and Punishment*, but as yet, no provisions have been made to issue protective orders to keep alleged abusers away from victims.

Several studies have found that half of all married

women have been the victims of violence by their husbands. Incidents of violence occurred within the first year of over half of the marriages and 20% of the wives were battered more than once a week. Battered wives experienced physical, emotional and mental pain. The most common physical symptom was acute headaches, bruises, and then broken bones. Some women have had miscarriages during a battering incident. Most battered women lose their trust in others and avoid social gatherings. Unfortunately, the violence is perpetuated in subsequent generations (KWDI, 1993; KIC, 1992).

There are also very few service agencies for such victims, leaving battered women few options for receiving help. Only thirteen privately-funded shelters and two government-funded shelters for battered women have been built. There are a few legal and medical assistance programs in existence, but as yet no domestic violence prevention programs have been provided.

Rape and Incest

Rape and incest has increased in connection with the rapid changes society has undergone, such as industrialization. However, awareness of rape and incest is low, and many Koreans still blame the victims of rape and incest for these crimes. Few cases of rape and incest are ever reported, and very

seldom are suspects actually indicated in those reported cases. According to statistics from 1992, 12.5 people were raped per 100,000 people. However, it is estimated that only 2.2% of all rape victims report the incident. According to police records, rape rates in Korea are the third highest in the world(just after America and Sweden). Taking into consideration the low rate at which cases are reported, we can estimate that approximately 200,000 women a year are raped(KWDI, 1994).

Because most of the victims feel deeply ashamed of the event and tend to keep their experiences a secret, they do not receive appropriate psychological treatment, and thus the psychological effects of the incident become stronger and deeper(Park, 1994; SPPO, 1992; KIC, 1989). For those that do come forward, there are no government-funded shelters for sexually abused women, and only a few private, battered women's shelters provide such services. Services for those victims are practically nonexistent in Korea.

A "*Special Law for Sexual Violence*" was implemented in 1994. Counselor-training programs for sexually abused women have also been developed recently(KIC, 1989; TSPPO, 1992; KWDI, 1992, 1994).

Prostitution

In Korea, selling or buying sexual services has become a serious problem, with many people becoming

increasingly worried about this situation and seeking solutions. Prostitution is conducted secretly and on an individual basis. It is estimated that new kinds of prostitution have appeared, such as hostesses, call girls, shaving girls, massage girls, and male prostitutes. Root conditions causing prostitution are poverty, which may also result from the rural to urban migration of women. They are not only drawn into prostitution with dreams of escaping poverty, but also lured by recruiters' promises of providing a good job. In some cases, middle and high school drop-outs (most of them are under age 18) had jobs as waitresses in pub houses, but turned to prostitution in the end.

Although the *Prostitution Prevention Act* was enacted in 1961 and is still in effect, administrative actions have not reduced prostitution. All the government has been able to do is encourage the prostitutes to be checked regularly for sexually transmitted diseases. Strong administrative actions to reduce prostitution, and the establishment of counselling centers and safeguard facilities are necessary. Moreover, fundamental changes will only be possible when dual norms about sexual behavior disappear in Korea.

The government is currently trying to revise the *Anti-Prostitution Act* and is considering rehabilitation programs as part of the prostitution prevention law. As of 1991, there were 101 Women's Counselling Centers, including 79 simplified ones in major cities,

providing counselling services to these women. There are 26 vocational guidance centers providing prostitutes with vocational training and education for their social reintegration. More experts are needed, however, to counsel these women(Park, 1994).

Chapter 4
Health Services

Distribution of Health Facilities

Korea's health care system depends primarily on the private sector to provide curative care, and this is why most medical facilities are concentrated in urban areas. Private clinics and hospitals comprise more than 99.7% of all medical facilities, 85.4% of all beds, and employ 83% of all physicians.

Table 19. Regional Distribution of Health Resources in 1992

(Unit:%)

	Urban areas	Rural areas
Population	75.6	24.4
Hospital beds	85.9	14.1
Physicians	93.1	6.9

Source: MOHSA, *1994 Major programs for Health and Social Welfare.*

To overcome the problem of an unequal distribution of medical resources, the government has continuously tried to replenish the supply of medical manpower and facilities in rural areas since 1978 (MOHSA, 1994). To improve the unbalanced distribution

of medical facilities between urban and rural areas, the government provides financial incentives, such as long-term, low-interest loans, to those who establish medical facilities in rural areas or industrial complexes with public doctors. The government has also expanded primary health facilities and provided them with modern medical equipment in an effort to improve health services for people in rural and fishery areas.

The government enacted a special law in 1980 to allow "Public Health Doctors" to work in medically underserved areas instead of doing their military service. The government established 1,303 health subcenters in rural and fishery areas, and 2,301 public health doctors were posted at health subcenters in 1994 (MOHW, 1995).

The *Special Law for Primary Health Care in Rural and Fishery Areas* was enacted in 1981. As of 1995, 2,039 Primary Health Care Posts(PHP) had been established. Community Health Practitioners(CHP), qualified nurses or midwives who have completed 24 weeks of special job-training provide primary health care at these centers, performing preventive health care activities and basic medical treatment(MOHSA, 1994).

Accessibility of Health Services for Women

Place of Delivery

Table 20 shows the frequency of women having babies delivered according to the place of delivery. According to the 1994 National Fertility & Family Health Survey, 98.8% of all deliveries took place at health facilities and there is very little difference in this number between urban and rural areas. Clinics are the most common place for delivering babies, and general hospitals are second.

Table 20. Number and Percentage of Women by Place of Delivery

(Unit: %(number))

	Whole country	Urban	Rural
General Hospital	31.8	32.5	28.1
Hospital	21.3	21.5	20.2
Clinic	43.1	43.2	42.6
Midwifery Clinic	2.0	1.8	3.0
Health Center	0.7	0.4	2.2
Home & others	1.2	0.7	3.9
Total	100.0(1,932)	100.0(1,622)	100.0(310)

Source: 1994 National Fertility & Family Health Survey.

Accessibility and Utilization of Family Planning Services

In 1994, 77.4% of all married women aged 15~44 practiced contraception. Sterilization was the most

common form of contraception among married couples, with 28.6% having had tubectomies and 11.6% having had vasectomies.

Most Korean couples employ female contraceptive measures rather than male-oriented ones. In 1991, the use of permanent contraception by women was 35.3% compared to 12.0% by men. Of all married couples, 79.4% used contraceptives-57.2% by women and 22.2% by men(Song, 1992). People in rural areas are more likely than those in urban areas to use permanent methods.

Table 21. Percentage of Contraceptive Users by Method

(Unit: %)

	Whole country	Urban	Rural
Tubaligation	28.6	26.8	37.1
Vasectomy	11.6	11.6	11.6
IUD	10.5	10.3	11.4
Oral Pill	1.8	1.8	1.8
Condom	14.3	15.8	7.4
Spermicide	1.3	1.3	1.2
Rhythm method	7.3	7.4	6.7
Others	2.0	2.2	1.2
Total	77.4	77.1	78.4

Source: 1994 National Fertility & Family Health Survey.

Table 22. Percentage of Contraceptive Users by Source of Supply

(Unit: %)

	Government Support	Medical Insurance	Self-paid	Others	Total
Tubaligation	74.9	5.7	17.2	2.1	100(1,475)
Vasectomy	76.7	4.0	11.9	7.4	100(602)
IUD	32.6	6.0	60.6	0.8	100(539)
Oral Pill	5.4	-	94.6	-	100(93)
Condom	6.0	-	92.9	1.1	100(742)
Spermicide	-	-	100.0	-	100(64)
Total	50.0	4.0	42.5	2.5	100(3,514)

Source: 1994 National Fertility & Family Health Survey.

Government policy concerning contraceptive distribution changed recently. A self-pay system has been instituted, but support for the lower income class has been consistent. The current government family planning program is centered on the lower income class.

Sterilization and IUD services can also be obtained through medical insurance, while condoms and spermicide are sold through commercial pharmacies. Recently, condoms also started being sold in vending machines and through mail order by PPFK.

More than 70% of all married women received government supported services in 1994. Specifically, 74.9% obtained tubectomies with government support, 5.7% used medical insurance, and 19.3% paid for the operations themselves(Hong, 1994).

Provision of Support for Maternity

Pregnant women who are considered indigent and are registered at health centers are given regular medical examinations free of charge. Most receive prenatal services at least nine times, including examinations for anemia, urine, and blood pressure. Those who are found to have abnormalities receive follow-up examinations and treatment, if necessary. In 1992, 96.1% of all Korean women saw a doctor for prenatal care.

All maternal and child health(MCH) centers, private clinics, and hospitals issue MCH handbooks when they confirm pregnancies and provide them with MCH services(MOHSA, 1994). Pregnant women considered to be at high risk are cared for exclusively by health centers. High-risk pregnant women are those below 20 years or over 35 years of age and those with hypertension and diabetes(MOHW, 1995).

Child care leave provisions were introduced in 1987 through the *Equal Employment Opportunity Act*. Under this Act employers must grant requests for a leave of absence when a female worker with child under one year old requests time to take care of the child. Article 11(2) of the Act sets "the length of leave as one year, including the paid maternity leave before and after childbirth(60 days) stipulated in Article 60"(Elim Kim, 1994).

The rapid fertility decline and government efforts

engendered an improvement in maternal and child health. The introduction of a national health insurance system in 1989 has particularly contributed to the improvement of maternal and child health(MCH) services. Utilization of MCH services at hospitals and clinics has increased sharply, while utilization of MCH centers has decreased. The average frequency of prenatal care was ten visits in 1994, according to the '94 National Fertility and Family Health Survey.

Curative services are mostly provided by the private sector under the national medical insurance program, and the technology available is comparable to that of advanced countries. Preventive services and primary health care services, such as prenatal and postnatal care, health examinations, and immunization, are delivered to the indigent free of cost at health centers.

Although there has been great progress in maternal health, there are still problems that need to be solved soon.

The following is list of the current problems with MCH services.

1) Fewer services are being offered by the public sector: population coverage of the MCH program (public) in 1993 was 8.2% of the target population.
2) The MCH handbook is being underutilized: MCH handbooks are issued upon confirmation of pregnancies to the patients for the provision

of health information and the recording of health check-up results. However, it is not being well utilized, because very few among the medical personnel actually record the results of health examinations in it.

3) The rate of Cesarian Sections has increased from 9.6% in 1986 to 28.1% in 1993.
4) A low breast feeding rate has been discovered (1994 National Fertility Survey): breast feeding rate 11.4%; mixed feeding rate 60.7%; milk feeding rate 27.9%.
5) Services for low birthweight and premature infants are poor.
6) Evaluating MCH status is difficult due to insufficient information related to MCH statistics.
7) A poorly coordinated system of obstetrical emergency care exists between the public and private sector and among primary/secondary and tertiary care facilities.
8) Little attention has been given to the outcome of childbirth for young unwed mothers.

Use of Health Care Facilities

A study of the utilization pattern of health facilities has shown that urban and rural residents use health care facilities at almost the same rate. More than half of those surveyed said they visit hospitals or clinics more than once a year(urban 52%,

rural 50%). The annual average length of hospitalization was 0.93 days nationally, 0.87 days in urban areas, and 1.13 days in rural areas. This may be due to differences in age structure, that is to say, in the fact that an old age structure exists in rural areas. A much larger difference between utilization rates of health facilities between urban and rural residents was found in 1989 than in 1992. The introduction of a national medical insurance program and improved rural health facilities are probable factors behind the increased use of health facilities by rural residents.

In terms of gender differences, hospital admission rates are lower for women than men in every age group. The average length of stay is 18.2 days for men and 10.5 days for women(Song, 1993; Kim, 1994). Despite increased accessibility to health services, Korean women visit hospitals far less frequently than Korean men do(Hong, 1993; Park, 1994; Park, 1993). Furthermore, elderly women were less likely than elderly men to be hospitalized. This is not because elderly women are healthier than elderly men, but because of the gender differences in health related behaviors and socioeconomic conditions.

There are few specialized hospitals for elderly people with chronic diseases, but the need for them is increasing(MOHW, 1995; Song, 1993; Bang, 1993).

Table 23. Annual average admission rate of the elderly (60+)[1)]

		Total	60~64	65~69	70~74	75+
Total		10.7	10.2	9.3	11.9	12.4
Region	Urban	11.1	10.6	9.1	11.5	14.5
	Rural	10.2	9.6	9.5	12.5	9.8
Sex	Male	11.2	10.2	10.1	9.2	18.0
	Female	10.4	10.2	8.7	13.7	9.8

Note : 1) admission rate= (number of the aged with admission experience during last one year/total number of the aged surveyed) x 100

Source: Rhee, *Study on the Lifestyle of the Aged and the Policy Issues*, KIHASA, 1994

The government has been operating welfare institutions free of charge or for a low cost for the elderly without family members who can take care of them. However, the number of elderly who need charged nursing home or charged home for the elderly will increase rapidly due to the ageing of society and nuclearization of the family. The government revised *Elderly Welfare Act* in 1993~1994 to stimulate private enterprise or individual participation in building diversified charged welfare institutions for the elderly.

Table 24. Number of the Elderly Persons by Welfare Institutions

	Institutions	Number of the aged
Total	141	8,089
Home for the elderly	82	4,897
Nursing home for the elderly	36	2,418
Cheap sanatorium and charged nursing home	23	774

Source: MOHW, *Yearbook of Health and Social Statistics*, 1995.

Integration of Preventive and Curative Services

The integration of curative and preventive activities has rarely been realized in Korea, with the exception of maternal and child health services. The *National Health Promotion Law* was enacted in January, 1995, with health promotion policy and strategies to be developed soon. The integration of preventive and curative health services will hopefully be addressed soon as it is an issue that should be resolved in the near future.

Hospital-based Activities that Support Health Promotion and Primary Health Care

Some of the special hospitals for women and general hospitals have recently opened comprehensive women's health clinics or health promotion centers for lifelong health management. These clinics and centers provide

screening services for the early detection of disease and services for counselling, health and nutritional education and information, obesity, exercise, and menopause. However, while the need for these kinds of services is increasing, they are only accessible to the affluent because such services are not covered by medical insurance.

Health Education and Training Programs

The Ministry of Health and Welfare(MOHW) has developed various materials for health education and distributed them to local government authorities. It has also arranged training courses for health personnel to adapt to the rapidly evolving health environment. To enhance the effectiveness and efficiency of the health education system, MOHW has strengthened its health education material development center which collects and publishes available information and develops education materials.

Health education programs conducted by the MOHW include:

1) health education material production;
2) health worker training;
3) establishment and public advertisement of national dietary guidelines;
4) an anti-smoking program that includes placing a health warning statement on cigarette

packs, delineating non-smoking areas in public areas, and prohibiting the sale of tobacco to minors; and

5) parasite eradication education(MOHW, 1995).

Gynecological Care

Government policies focusing on middle-aged and old-aged women are rare. On the other hand, more physicians in the private sector are becoming interested in gynecology because of a lower rate of the obstetric service fee fixed by medical insurance. Gynecological care mainly focuses on post-menopause and cancer.

Post-menopause

More and more middle-aged and old-aged women are taking estrogen hormones to keep fit and to prevent osteoporosis. Many also undergo breast cancer screening.

Cancer in Women

Cervix and breast cancer are the most common types of cancer found in Korean women. Most cancer screening services are provided at private clinics. Pap smears are the major method of detecting cervix cancer, while ultrasonographic examinations are used to detect uterine myoma and film mammography and

ultrasonographic examinations are used to detect breast cancer. The government provides free screening services for cervix cancer to selected low-income earning women aged 40-49 and plans to increase the number of recipients in the future. In 1993, 129,295 women received these services with government support(MOHSA, White paper, 1994).

According to the cancer registration record, 39 of every 100 female cancer patients have cancer of the cervix, breast, or ovaries(MOHSA, 1993, 1994).

Services that Support Healthy Sexuality

Almost all married couples participate in family planning programs, but such information is not easily available to the rest of the population, especially youths. Korean society is rapidly becoming modernized, but sex norms are still very restrictive where adolescents are concerned. Several studies have reported problems with adolescent sexuality. Adolescents show a strong desire to receive information on reproductive physiology and contraception, but they have little opportunity to do so.

Although Korea has few AIDS patients compared with other countries, statistics have shown a gradual increase in AIDS cases among younger people and women. No routine HIV screening services are available now, except for those to test prostitutes who are

under the supervision of the Ministry of Health and Social Welfare(MOHW, 1995).

MOHW also provides specific counselling and voluntary HIV testing services for homosexuals. HIV screening of donated blood was made mandatory in July, 1987, and efforts are being made to improve the quality of the laboratory work. Since the cooperation of HIV seropositives is necessary to successfully curb further AIDS transmission, the government is making every effort to abolish discrimination and stigmatization against infected persons. The focus has been on counselling and education, health monitoring, financial support, and AZT treatment(MOHSA, 1994; Park, 1994; Hong, 1989; WHO, 1989).

Though there are no reliable statistics on the prevalence of STDs in Korea as yet, MOHW has been taking steps to control the spread of STDs. These activities include registering prostitutes at health centers and encouraging them to receive regular STD check-ups, as well as educating prostitutes, seafarers, and international travellers, and providing education materials to homosexuals and youths.

Community Stress Management Programs

Psychiatric disorders have been increasing recently due to rapid changes in the living environment. The need for stress management education programs has increased recently, but few community-based mental

health programs exist. *The Mental Health Act* was enacted in December, 1995, in an attempt to enhance mental health of the population in response to the increased incidence of psychiatric disorders. The Act defines the details necessary for preventing mental disorders and providing effective psychiatric care and rehabilitation. The Act will enable the government to make policies supporting community mental health promotion.

Occupational Health Services

Women were less likely than men to be injured at work(Table 25). This may because men are more likely than women to be exposed to risk at work.

Access to Occupational Health Services

The Korea Industrial Safety Corporation Law allowed for the establishment of the Korea Industrial Safety Corporation which is composed of a headquarters and four affiliated organizations: the Industrial Safety Research Institute; Industrial Health Research Institute; Industrial Training Institute; and Branch Offices. Recently, the Korea Industrial Safety Corporation ran worksite programs to promote rest, exercise, nutrition, and stress management.

Korean Industrial Health Association(KIHA) was founded in 1963 with seven special committees

subsequently established in 1964. The committees address the following issues: compensation for industrial accidents, phenumoconiosis, health management, academic activity, occupational diseases, environmental health, and education and training.

The proportion of injured female workers is about 10% of the total number of injured workers. This lower rate may be due to the lower participation rate of women in industrial jobs and because they work in less dangerous environment than men do. The rate of injured workers has been decreasing steadily since 1980(Table 25).

Table 25. Injured Workers in Industrial Accidents by Sex

	Workers Covered by Industrial Accident Insurance	Injured Workers				Rate of Injured Workers
		Total	Female	Male	Female(%)	
1980	2,584,673	113,375	-	-	-	2.58
1985	4,485,185	141,809	16,200	125,609	11.4	2.68
1990	7,542,752	132,893	13,146	119,747	9.9	1.76
1991	7,922,704	128,169	12,965	115,204	10.1	1.62
1992	7,058,704	107,435	11,026	96,409	10.3	1.52
1993	6,942,527	90,288	9,023	81,265	10.0	1.30

Source: Korea Women's Development Institute, *Statistical Yearbook on Women*, 1995.

Out of 4,104,134 workers, 3,468,092(85%) of them received a health examination in 1994. From the examination results, 162,983 workers were discovered to have diseases(prevalence rate 4.67%), and 3,084 of those patients were found to have an occupational disease(Table 26).

Table 26. Health Examination of the Workers(1994)

	No. of workers			No. of patient discovered		
	Target	Achievement	%	Total	Disease	Occupational disease
Total	4,104,134	3,468,092	84.9	162,983	159,899	3,084
General exam.	3,445,203	2,843,447	82.5	129,857	129,842	15
Special exam.	658,931	642,645	97.5	33,126	30,057	3,069

Source: Ministry of Labor, *White Paper on Labor*, 1995.

According to projections by the Ministry of Health and Social Welfare, the number of children needing accommodation services were 1.021 million in 1995 (White Paper on Health and Social Welfare, 1995). The proportion of accommodated children was only about 20% of this estimated demand; moreover, public day care center services account for only one third of the accommodated children. The government should actively deal with the situation, because the demand is expected to increase steeply with increasing female participation in economic activity and the growing number of nuclear families.

Table 27. Day Care Center and Accommodated Children (1994)

	No. of facilities	No. of children
Total	6,975	219,308
Public day care centers	983	70,937
Private day care centers	3,091	119,968
Day care centers in the work place	37	976
Home day care centers	2,864	27,427

Source: MHW, *The Yearbook of Health and Social Statistics*, 1995.

Health Insurance Scheme

The health insurance scheme introduced in 1977 expanded its coverage to the self-employed persons in rural areas in January, 1988, to private companies with more than 5 employees in July, 1988, and to the urban self-employed in July, 1989. It took only 12 years to achieve universal coverage within the health insurance scheme. The scheme has been developed as part of the social insurance system, and it is mandatory for all individuals falling into the scheme (MOHASA, 1993).

The scheme is managed by the Health Insurance Societies, which are nonprofit organizations established on the basis of either the work place for wage earners or residential area for the self-employed. However, a Health Insurance Corporation for the government/private school employees administers a health insurance program for these employees throughout the country. The National Health Insurance Federation assists and supports each society and all health insurance societies and corporations are members of the Federation.

The main source of finance for the health insurance is contributions. Employees and employers pays half of the contribution for the employees health insurance program. The government pays half of the contributions for its own employees and 20% of the contributions for the private school employees. In addition, the

government subsidizes self-employed health insurance society's administrative cost from general revenue.

The insurance scheme has a 'third party' payment system in which medical services for the beneficiaries are provided by the medical practitioner or medical facilities not owned by the insurer, and those medical service providers are reimbursed by the insurer on the basis of fee-for-service.

Each year a committee in the MOHW evaluates all the items of medical services and medicine available for the beneficiaries and sets the fee schedule. Each medical service provider prepares a bill for their services according to the fee schedule, while each insurer(society or corporation) pays the fees to them after deducting the amount borne by the patient. To secure medical care for those who cannot afford to pay the contributions, the government administers a non-contributory program, called the Health Aid Program, which is financed from general revenue. This scheme was introduced in 1977, and at present it covers 4.3% of the entire population.

When the insured or their dependents receive medical care services, they should pay a partial amount of the total costs. In the case of hospitalization, the insured or their dependents should pay 20% of the total costs(MOHW, 1996).

On July 1, 1989, the government established a national regionalization system for medical services.

Regionalization consists of delimitation of a region and the development of graded services, and a patient referral system. The proportions of patients using medical facilities within medical catchment areas are diverse, indicating that health needs are not being fully met in certain areas(Kim, 1994).

Chapter 5
Conclusion

Objectives for Women's Health

The development of a *National Women's Health Policy* was first proposed at the *National Women's Health Conference* in 1985, *International Women's Year*. However, the Korean government has not set any specific or comprehensive objectives focusing on women's health other than the plan for improving maternal and child health care. Therefore, priority should be given to the formation of objectives for women's health. Policies for women's health should go beyond biomedical aspects of health because the health condition of women is inextricably intertwined with the social and economic environment and women's position in that environment.

Public Debates on Women's Health Issues

Though contraception is widely practiced, the rate of induced abortions is very high among both married and unmarried women. Moreover in 1993, 87% of all adopted children were born to unwed mothers. Health education and contraceptive services

must be improved to reduce this risk to women's health in Korea.

The government has not done enough to try to prevent unwanted pregnancy because many Koreans believe that providing contraceptive services will stimulate sexual activity among adolescents. Few facilities for the protection of unmarried mothers during their pregnancy and after delivery are available. Policies need to be developed to prevent pregnancy, rather than simply reacting to it, and proper services should be given to the ones who need it most.

Health Policies for Women

In principle, men and women have equal access to health care in Korea. This principle notwithstanding, few health policy decisions have focused on women because there is no gender perspective on health in Korea. The Constitution states that the health of all citizens shall be protected. However, women visited hospitals less frequently than men despite the fact that the morbidity rate is higher for women than for men. Hospital admission rates are lower for women than men in every age group. It seems obvious that women's demand for health services are not being met.

Strategies for Policy Implementation

It has been difficult for the government to direct the Korean health care system because it depends so heavily on the private sector to provide curative services. Intersectional coordination had been limited in the past, but new environmental changes, such as the decentralization of power due to the introduction of local self-government and the establishment of the *National Health Promotion Act,* are promising steps for the future. Since the establishment of the National Health Insurance System, the government has been able to control medical facilities. Also, coordination among sectors can be arranged under strategies outlined in the *National Health Promotion Act*. A range of women's health issues and regional differences can be managed comprehensively with these changes.

Current Reform Efforts to Improve Health Services for Women

The Korean government has taken positive steps to enhance women's status at both the government and private levels. The government is planning to develop nursing homes for the elderly and childcare facilities at workplace because as women participate more in the workforce in ever increasing numbers, they became less able to care for them on their own. In the near future, however, the Korean government

should make efforts to implement plans for the *'Long-term Perspective on National Development toward the year 2000'* in accordance with the guidelines suggested by the United Nations in the *'Nairobi Forward Looking Strategies for the Advancement of Women'*. The guidelines promote the development of women's full capacities as a way to add to human resources and to lead healthier family lives(Yeon, 1995).

Policies and Mechanisms to Reduce Inequalities in Health Status

Women's health problems are different from those of men. The government should identify vulnerable areas and implement policies to reduce them. In order to develop better health policies and to reduce gender inequality, we should begin gathering more health statistics classified by sex and conducting more gender-specific health research.

Program Designed since 1990 to Eliminate Discrimination

To improve the level of national health, medical care, and social welfare services to all Koreans, the government has a plan to implement the following policies(MOHSA, 1994):

1) improve national nutrition and advance maternal and child health care;

2) prevent disease and manage acute and chronic diseases effectively by improving health education;
3) establish a system for income security in cases of sickness and death(in 1992 the national pension system coverage was extended to companies with at least five employees);
4) expand social welfare services for the poor, the elderly, the disabled, and children.

Suggestions to Solve the Abnormal Sex Ratio Issues

According to the national action against son preference provided by the United Nations(UN, 1995), parents should be educated to value the worth of a female child so as to eliminate such biases. Governments are encouraged to mobilize educational institutions and the media to change negative attitudes and values towards the female gender and project a positive image of women in general, and the female child in particular.

To successfully solve the problem of prenatal sex-selection, the restriction on the medical services is not enough because discrimination against women still exists in society and at home. Therefore, the best way to solve this problem is to increase the status of women. For this purpose, women should be given opportunities to participate in policy making. Women cannot get involved in the decision making

process in society unless both their family and their surrounding society support them. Raising women's power in society will require more organized action. In this respect, "*The Beijing Declaration and Platform for Action*" from the fourth World Conference on Women can serve as an important action strategy for women in Korea.

Future Policy Implications

Following the 4th World Conference of Women held in Beijing, the Korean government adopted various kinds of policies for women, such as a Quota System in the public sector, in response to the Platform for Action suggested by the UN, a blueprint for women's advancement in countries around the world.

The World Conference on Women held in Beijing provides a precious opportunity to promote women's health and well-being and their full participation in all aspects of social development. The great challenge is what will be faced after Beijing. It is important to translate the Platform for Action into regional priorities and to begin lending assistance between different regions.

We now have an opportunity for the international community to commit itself and take action to accelerate equality between women and men and to ensure their equal participation in all spheres of public and private life. At this critical time, we all

must prepare to use our skills, experience, knowledge and vision to facilitate action by governments and international and non-governmental organizations to achieve these goals.

Beijing Declaration declared that Governments are determined to:

1) intensify efforts to achieve the goals of the Nairobi Forward-looking Strategies for the Advancement of Women by the end of this century;
2) take all necessary measures to eliminate all forms of discrimination against girls and women and to remove all obstacles to gender equality and the empowerment of women and girls;
3) promote and protect the human rights of all women and girls;
4) promote the full and equal participation of girls and women of all ages in building a better world for all.

The following are the key issues for women and health in The Beijing Declaration and Platform for Action. These issues include reproductive health, sexual health, environmental health, occupational health and malnutrition.

1) Development and implementation of gender-sensitive health programs
2) Provision of primary health care
3) Giving special attention to the health needs of female children

4) Women's active participation in the policy-making process regarding HIV/AIDS and other sexually transmitted diseases, and development of strategies to protect women from those diseases
5) Promote researches on women's health, increase the number of female policy makers in the area of health, and encourage provision of resources on women's health and diffusion of research findings
6) Increase financial fund for health and medical, and social services

Reference

Bang, S. & Cho, Y.H., *Health Policies and Programs for the Aging Population towards the 21st Century in Korea*, Paper presented to the Symposium of the Korean Gerontological Societies, 1993. (Korean)

Byun, H.S., Won, Y.A., Choi, E.Y., *A study on the Countermeasure on Domestic Violence-focused on Wives Abuse*, Korean Women's Development Institute, 1993. (Korean)

Chang, S. J., *Population and Family Planning in Korea*, Papers for the Korea Program of the 23rd EWPI Summer Seminar on Population, June, 1992. (Korean)

Cho, N. & Kim, H.O., *Korean Experience with Population Control Policy and Family Planning Program Management and Operation*, KIHASA, 1991. (Korean)

Choi, J.S., Nam, J.J., Kim, T.J. & Kye, H.B., *The Level of Health and Medical Utilization Practice of the Korean People*, KIHASA. (Korean)

Chosun Daily Newspaper, *Woman*, Sep.19, 1995, p. 34.

Han, J.J., Kim, S.O., Kim, W.H., *A study on the Measures for the Elimination of Discrimination Against Women in the Public Sectors of Various Countries*, KEDI, 1993. (Korean)

Hong, K.E., Kim, S.E., Hong, M.S., Cho, N.H., Suh, M.H., *Health Issues of Korean Youth and Their*

Counter-measures(WHO/WP), Korea Institute for Population and Health(KIPH), 1989. (Korean)

Hong, M.S., Lee, S.Y., Chang, Y.S., Dh, Y.H., Kye, H.B., *National Fertility and Family Health Survey, Korea Institute for Health and Socail Affairs*, 1994. (Korean)

Hong, M.S., Lee, L.J., Lee, S.Y., *A Study on the Induced Abortion Status*, 1990. (Korean)

Hong, M.S. & Hwang, N.M., "MCH Service System in Korea and Problems of Services in the Community", *The Journal for Korean Society for Health Education*, Vol.10, No.1, 1993. pp. 98~103. (Korean)

Hong, M.S., Lee, S.Y., Chang, Y.S., Oh, Y.H., Kye, H.B., 1994 *National Fertility & Family Health Survey Report*, KIHASA, 1994. (Korean)

KIHASA, *A Comparative Study on the Welfare Policy and Lifestyle of the Aged in Asian countries*, 1994. (Korean)

KIHASA, *1995 Disabled People Survey*, 1995. (Korean)

Kim, Elim, "Child Care Leave Systems", *Women's studies forum*, Vol.10, KWDI, 1994, pp. 5~23. (Korean)

Kim, S.C. & Kim, E.J., *Medical and Health Policy Issues Towards 21C*, KIHASA, 1994. (Korean)

Ko, C.K., Park, N.H., Kim, S.H., Lee, K.E. *Income security measures for the aged*, KIHASA, 1992. (Korean)

Kong, S.K., Choi, A.J., Kim, S.K., Son, S.H., *Fertility behaviour and Family Formation in Korea*, KIHASA, 1992. (Korean)

Korea Institute for Health and Social Affairs, *1994 National Fertility and Family Health Survey*, 1994. (Korean)

Korean Women's Development Institute, *Statistical Yearbook on Women*, 1994. (Korean)

Korean Institute of Criminology, *A Study on the Domestic Violence and its Countermeasures-Focused on Husbands' Violence towards Wives in Seoul*, 1992. (Korean)

Korean Institute of Criminology, *Sexual Violence and Its Countermeasures in Korea*, 1989. (Korean)

Korean Public Health Association, *Symposium on Establishing National Health Status by the year 2000*, 1995. (Korean)

Korean Women's Development Institute, *Codebook for Women*, 1992. (Korean)

Korean Women's Development Institute, *Programs for the Counselor for the Sexual Violence*, 1994. (Korean)

Korean Women's Development Institute, *A study on the Countermeasure on Domestic Violence-focused on wife abuse,* 1993. (Korean)

Korean Women's Development Institute, *Statistical Yearbook on Women*, 1994. (Korean)

Korean Women's Development Institute, *A Study on Countermeasures against Sexual Violence*, 1992. (Korean)

KWDI, *Social Statistics and Indicators on Women*, 1994, p. 343. (Korean)

Ministry of Health and Social Affairs, *Yearbook of Health and Social Statistics*, 1995. (Korean)

MOHSA, *1993 Major Programmes for Health and Social Welfare*, 1993. (Korean)

MOHSA, *1994 Major Programs for Health and Social Welfare*, 1994. (Korean)

MOHW, *1996 Major Programs for Health and Social Welfare*, 1996. (Korean)

MOHW, *'95 Plan of Family Health Program*, 1995. (Korean)

MOHSA, *Report of Korean Cancer Registration Investigation*, 1993. (Korean)

MOHSA, *'94 White Paper on Health and Social Affairs*, 1994. (Korean)

MOHW, *'95 White Paper on Health and Welfare*, 1995. (Korean)

Ministry of Labor(MOL), *White Paper on Labor*, 1995. (Korean)

Moon, H.S., Chang, Y.S., Kim, Y.K., Chun, H.S., *Current Status of Korean Family Health Program and the Policy Issues*, KIHASA, 1994. (Korean)

The National Pension Corporation, *National Pension Statistics*, 1991~1994. (Korean)

National Statistical Office(NSO), *1993 Annual Report on the Cause of Death Statistics*, 1994. (Korean)

NSO, *Korea Statistical Yearbook*, 1994. (Korean)

___, *Social Indicators in Korea*, 1994. (Korean)

____, *1990 Population and Housing Census Report*, 1991. (Korean)

____, *Social Indicators in Korea*, 1994. (Korean)

____, *Annual Report on the Economically Active Population Survey*, 1992. (Korean)

____, *Korea Statistical Yearbook*, 1994. (Korean)

____, *Change of Employment Status During the Last 30 years: 1963~1993*, 1994. (Korean)

Park, I.H., Hwang, N.M., Direction of Maternal and Child Health Policy, KIHASA, 1993, p. 204. (Korean)

Park, J.E., "Current Status of Health and Development of Women in Korea", Women's Studies Forum, Vol.10, KWDI, 1994, pp. 172; 181~182; 195~196. (Korean)

Rhee, K.O., Suh, M.K., Ko, K.W., Park, C.D., *Study on Lifestyle of Korean Elderly and Policy Issues*, KIHASA, 1994. (Korean)

Song, K.Y., Nam, J.J., Choi, J.S., Kim, T.J., *1992 National Health Behavior Survey*, KIHASA, 1993. (Korean)

Song, K.Y., Park, H.A., Lee, S.Y., Kim, T.J. *Comprehensive Analysis on the Utilization of Health Facilities and the Health Behavior*, KIHASA, 1993. (Korean)

The Supreme Public Prosecutor's Office, *Analytical Report on Crime*, 1992. (Korean)

Yeon, H.C., Baek, H. J., Park, I. H., *Social Development in Korea: An Overview*, KIHASA, 1995. (Korean)

Yoon, B.J. *A Study on Korean Health Status*

Assessment by Health Expectancy Concept, A doctoral dissertation, Graduate School of Seoul National University, 1995. (Korean)

Cook, R.J., *Women's Health and Human Rights*, WHO, 1994.

UN, *Human Rights*, 1995.

WHO, *Health Dimensions of Economic Reform*, 1992.

WHO, *Unmarried Female Worker's Sexual and Contraceptive Knowledge and Attitude*, KIPH, 1989.

WHO, *Women's Health(executive summary)*, 1995.

Appendix

UN 4th World Conference on Women

History of the UN World Conference on Women

When the First World Conference on Women was held in Mexico City in 1975, the adressed issue was to reduce gender inequality. With the evolution of the conference, the issue of development was dealt with at all levels at the Copenhagen Conference in 1980. At the Nairobi Conference in 1985, there was a new focus on peace. The Nairobi Conference adopted the "Forward-looking Strategies for Women" to be implemented by the year 2000. The United Nation's Fourth Conference on Women was held in Beijing, China, 1995. The Beijing Conference was a fusion of the three fundamental issues(peace, development and equality) on the agenda.

UN 4th World Conference on Women

International focus is now on such issues as population growth, health, violence against women, access to decision-making and the sharing of power, women's human rights and their contribution to safeguarding the environment. These concerns form

the basis of the Platform for Action, which spells out precise actions to realize the goals of the Conference - equality, development and peace.

Comparing the current conference with the previous three, this is the first conference taking place after the cold war, and it is the largest conference, with about 181 countries and about 50,000 governmental and non-governmental representatives participating. It is also by far the largest in terms of the NGO Forum.

This conference declared that women should share responsibilities and rights with men in every social setting and call for equal opportunity in every social sector, especially when it comes to policy making. The goals include equitable and sustainable development, founded on the principle of equality among the peoples of the world and between women and men in both private and public life. Furthermore, an Agenda for Equality proposed at the Beijing Conference seeks to safeguard women's human rights throughout their entire lives and to obtain commitments from governments for action to create a peaceful, developed and just world.

The Beijing Declaration and Platform for Action provided strategic objectives and actions for women in every country. Each country is responsible for reporting its enforcement plan and implementation process to the United Nation's Commission on the Status of Women. These strategies and actions are expected to be adopted in each country's policy.

The Paltform for Action: 12 Critical Areas of Concern

The draft Platform deals with the eleven identified areas of concern. The problems relating to the areas of concern are diagnosed, and strategic objectives are proposed, with concrete actions to be taken by various actors to achieve these objectives.

The critical areas of concern are

1) The persistent and increasing burden of poverty on women;
2) Unequal access to or inadequate educational and training opportunities of good quality at all levels;
3) Inequalities in health care and related services;
4) All forms of violence against women(and the female child);
5) Effects of persecution and armed or other kinds of conflict on women(in particular those living under foreign occupation or alien domination);
6) Inequality in women's access to and participation in the definition of economic structures and policies and the productive process itself;
7) Inequality between men and women in the sharing of power and decision making at all levels;
8) Insufficient mechanisms at all levels to promote the advancement of women;
9) Promotion and protection of all(universal) human rights of women;

10) Women and the media;
11) Women and the environment;
12) Discrimination against and violation of the rights of the female children.

Women's Major Health Issues

The major women's health issues from diverse religious and cultural backgrounds were identified as women's right of decision-making in the area of sex, pregnancy, and delivery, elimination of governments' discriminative policies against women who have undergone abortion, and problems related to teens' sexual life. The last three controversial issues were:

1) how to reflect the agreement on the right to sexual and reproductive health in the chapter on human rights, as well as in the Beijing Declaration;
2) how to express in terms of agreed language the issues of cultural and national sovereignity with regard to issues of human rights;
3) whether to include sexual orientation as one of the grounds on which discrimination should be prohibited in the context of human rights.

The remaining points concerning the most sensitive issues were sexual rights, parental responsibility and illegal abortion. The government representatives participating in the Conference co-operated very well regardless of the fact that they came from different

regions and diversified religious and cultural backgrounds.

Through meetings during the Conference, the Health Committee Members came to an agreement on these issues. Women's rights include decision-making free from any force, unequal treatment, or violence in the area of sexuality related problems. The Committee decided to ask each country to amend legal restrictions on abortions. The committee admitted that the youth have the right to privacy, while parents also have the authority and responsibility of supervising their children. The youth should be granted the most benefits from any kind of policies related to them.

Other women's sexuality related issues discussed were female genital mutilation and prenatal sex selection. The female genital mutilation, which is practiced in certain countries in Africa, some in the Middle East, and a few in Asia, is a tradition deeply embedded in patriarchal power structures and the desire to control women's lives. Young girls in some immigrant communities in Australia, Canada, Europe and the U.S.A. are also subjected to female genital mutilation. Prenatal sex selection is an extreme consequence of son preference embedded in some cultures and countries. The high value leads to discrimination with serious health consequences for girls and women.

Outcome of the Conference

Although the representatives from countries all

over the world were directed toward the same goal, their interest was very different according to the current socio-economic, cultural and political situation in their countries. Developed countries talk about equality, while developing countries talk about development. Eastern European countries on the other hand ,talk about peace. Korean issues are more closely related to the developed countries, especially on health issues, although Korea has some problems related with culture.

Due to the dedicated efforts of the participants, agreement on the full text of the health chapter of the Platform for Action was reached. Consensus on the health chapter is the most remarkable achievement of the Conference. Health experts were fully involved in the negotiations, and the concerns of all countries were addressed.

The Platform for Action should be of great interest to nations in Asia and the Pacific region. Regional action would be important for the implementation of the platform, and this refers to the co-operation among the nations in Asia and the Pacific region.

The Convention on the Elimination of All Forms of Discrimination Against Women(CEDAW) was adopted by the UN General Assembly in 1979. CEDAW obliges states which ratify the convention to take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise. In August, 1995, 145 nations ratified the convention.

In order to better implement the convention, the International Women's Rights Action Watch(IWRAW) provides many training courses for women to help them understand the means of accessing the rights and the obligations of the government. Now, it uses the existing reporting mechanism to force the state to examine its laws and practices.

Women have gained a lot from the fact that many nations have felt compelled to comply with the previous convention's declarations. We should move to hold the states accountable when there is violation of human rights.