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Population and Development in Korea

- Focus on the ICPD Programme of Action -

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Preface

The International Conference on Population and Development (ICPD), the fifth population conference under the auspices of United Nations in Cairo in 1994, adopted a programme of action that establishes new guidelines for national and international action in the area of population and development for the next 20 years. 1999 is the fifth year since the Programme of Action was adopted and, hence, the United Nations has urged nations to conduct an evaluation on achievements made and constraints faced during the last five years, namely ICPD+5.

The Korea Institute for Health and Social Affairs(KIHASA), under the financial support of UNFPA, has therefore prepared this report. This report is devoted to identifying the current status, evaluating achievements and constraints, and suggesting future policy directions in the area of population and development in Korea. Specifically, this report focuses on reproductive health, including family planning and maternal and child health, adolescent sexuality, STD and HIV/AIDS, empowerment of women, family welfare, elderly health and welfare, population distribution, population and environment, and NGOs' roles in the implementation of the ICPD Programme of Action.

I sincerely hope that this report will help in guiding governmental and non-governmental organizations to successfully achieve the goals of the ICPD Programme of Action for the next 15 years, to 2015, in Korea. This report will be highly helpful to scholars and Government officials in related fields.

I would like to express appreciation for the generous support provided by the UNFPA, specifically Dr. M.. Nizamuddin, Director of the Asia and Pacific Division, without whose support this report would not have been possible. The authors, Dr.

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December, 1999

Kyungbae Chung, Ph. D.
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Abbreviations

AIDS	: Acquired Immuno-deficiency Syndrome
ADL	: Activities of Daily Living
AZT	: Azidothymidine
EPB	: Economic Planning Board
FP	: Family Planning
GDI	: Gender-related Development Index
GEM	: Gender Empowerment Measure
HDI	: Human Development Index
HIV	: Human Immunodeficiency Virus
ICPD	: International Conference on Population and Development
IUD	: Intra Uterine Device
KAAF	: Korean Anti-AIDS Federation
KDI	: Korea Development Institute
KIHASA	: Korea Institute for Heath and Social Affairs
KWDI	: Korean Women Development Institute
MCH	: Maternal and Child Health
NGO	: Non-Governmental Organizations
PCWA	: Presidential Commission on Women's Affairs
PPFK	: Planned Parenthood Federation of Korea
RH	: Reproductive Health
SOC	: Social Overhead Capital
STD	: Sexually Transmitted Diseases
TB	: Tuberculosis

Chapter 1. Introduction

A. Background

The Programme of Action, adopted at the International Conference on Population and Development(ICPD) held in Cairo 1994, establishes a number of time-bound population and development goals for a 20-year period, from 1995 to 2015. The ICPD Programme of Action is, in principle, aimed at improving the quality of life for every individual, woman and man. It especially stresses the empowerment of women, both as a highly important end in itself and as a key to improving the quality of life for everyone.

The quality of people's life is strongly interrelated with population change, patterns and levels of use of natural resources, the state of the environment, and the pace and quality of economic and social development. For example, population growth influences poverty, which, in turn, is often accompanied by undernourishment, low status of women, and limited access to social and health services, including reproductive health services.

As a result of such complexity, all countries, particularly developing countries where almost all of the future growth of the world population will occur, face increasing difficulties in improving the quality of life of their people in a sustainable manner. This is why population concerns need to be integrated into the planning, implementation, monitoring and evaluation of all policies and programs relating to sustainable development and resource allocation at all levels.

The ICPD Programme of Action underscores the integral and mutually reinforcing linkages between population and development and subsequently many countries have increased political action

and public attention concerning the linkages between population and a country's social, economic and environmental concerns.

Until the early 1960s, the level of economic development in Korea was very low and population growth was high, resulting in poverty being prevalent throughout the country. The Korean government subsequently, adopted the national family planning program as part of the Five-Year Economic Development Plans, which started in 1962. The strong implementation of the National Family Planning program, together with changes in socio-economic conditions and economic development, resulted in a rapid decrease in population growth.

The population growth rate has been maintained far below the population replacement level(Total Fertility Rate 1.6) since the mid-1980s, which is why the Korean government made a transition from population control policy and adopted a new population policy in 1996.

The major goals of the new population policy were; 1) to maintain the below replacement level of fertility and to improve morbidity and mortality levels as part of the process of achieving sustainable socio-economic development, 2) to enhance family health and welfare; 3) to prevent the imbalance of sex ratio at birth and to reduce the incidence of induced abortions, 4) to tackle sex-related problems of youths and adolescents, 5) to empower women by expanding their employment opportunities and welfare services, and 6) to improve work opportunities and provide adequate health care and welfare services for the elderly.

Korea, like other countries, has made efforts to integrate population factors into their development plans since the 1994 ICPD, especially through the New Population Policy. In fact, such integration has been pursued in Korea since the early 1960's, with the launching of the economic development plan. However, there have been various barriers in implementation of the ICPD goals.

The chief constraints faced include the lack of political commitment and limited human and financial resources. In recent

years, the issue of the unnecessity of family planning, which has been raised in some countries, including Korea, because of the below replacement level of fertility, has also hindered the improvement of reproductive health. The increasing number of HIV/AIDS patients, adolescents' sexual problems, high prevalence of induced abortions, and sexual discrimination shows that family planning programs need to be continuously emphasized to control population growth in high fertility countries and to improve the quality and welfare of the population in low fertility countries.

Moreover, the recent economic crisis continues to compound these challenges; the financial and economic crisis in Korea has not only caused a reduction in real income and mass unemployment, but also has had widespread socio-economic consequences. The crisis is having immediate effects on levels of income, health, education, and overall social well-being. Thus, Korea is being faced with many new and serious challenges in the implementation of the ICPD Programme of Action.

In addition, the demands of the population for the improvement of their quality of life are increasing in diversity and a higher level of services needs to be met. In the 21st century intensive population policy will, therefore, be continuously important as a base in meeting the ICPD's ultimate goal, improvement of the quality of life. Specifically, intensive population policy will provide fundamental input for the achievement of "productive welfare" and facilitate security of basic livelihood in the new century.

B. Objectives

This report aims to evaluate achievements and constraints, specifically of the New Population Policy since 1996, and to suggest future policy directions for further implementation of the ICPD Programme of Action in Korea which will enable people to attain a better quality of life in a sustainable manner.

C. Report Framework

This report is composed of ten chapters. The first chapter is the introduction, and chapter 2 is devoted to identifying current and future population dynamics. Change in the components of population change, namely, fertility, mortality, international migration, change in total population size and population structure in Korea are introduced.

Chapter 3 deals with reproductive health, which integrates family planning and maternal and child health into general health schemes, and is composed of family planning, maternal and child health, including pre-natal and post-natal care, breast-feeding, pregnancy wastage, and induced abortions. Furthermore, the status of adolescent sexual activities is discussed, along with the constraints of related policies and programs. It also considers the transmission of STD and HIV and AIDS and the current policy and limitations of preventing those infections and managing infected patients.

Chapter 4 focuses on health, morbidity and mortality, as improving life expectancy along with health is a priority for improved quality of life. Specifically, this chapter evaluates the evolution of the health infrastructure, including related systems such as the health insurance scheme, and the new challenges caused by the shift from acute communicable diseases to noncommunicable chronic diseases.

The ICPD Programme of Action stresses improvement of gender equality and equity and empowerment of women, as an end and means of improving reproductive health and eventually quality of life. Therefore, chapter 5 deals with the current level of Korean women's status, evaluates women's policy and measures, and suggests future policy directions for further improvement of women's status.

Chapter 6 puts main focus on the health and welfare of the family of which the structure and role have changed rapidly with

the decline in fertility and mortality, predominant migration, and increase in women's labor force participation. This chapter stresses the impact of the recent economic crisis on family health and welfare, and suggests policy directions for improvement of family welfare under the economic recession.

Elderly health and welfare has become a main concern in recent Korean policy with the acceleration in population ageing. Thus, the main emphasis of Chapter 7 is evaluation of current policies and measures, which aim to improve the health and welfare of the elderly. Further health and welfare needs of the elderly are explored and future policy directions are suggested in this chapter.

Chapter 8 is devoted to population, development and environment and emphasizes sustainable development. In this chapter, past policy changes and results are evaluated and further efforts to improve the environment are elaborated upon. Chapter 9 focuses on the population concentration of the capital area, including Seoul, Inchon and Kyonggi-do, and also the concentration of political and administrative, socio-economic, and cultural facilities, along with their negative effect on the balanced development of the land.

In chapter 10, the roles of non-governmental organizations and the constraints they face are discussed. Based on these, efforts that should be pursued for the establishment of full partnerships with non-governmental organizations are suggested for successful implementation of the ICPD Programme of Action. The last chapter concludes this report.

Chapter 2. Population Change and Socio-economic Development

A. Transition in Factors of Population Change

1) Fertility

There was a significant increase in fertility level in Korea during the second half of the 1950s, due mainly to the post-Korean war[1] baby boom; the fertility level during this period was the highest in Korean history. The pro-natal attitude of the government during this period may have attributed to the high level(Kwon, 1977).

The total fertility rate in Korea(see Table 2-1) rapidly decreased from 6.0 in 1960 to a total fertility rate at the population replacement level of 2.1 in 1984. Thereafter, the trend in total fertility rate fluctuated between 1.6 and 1.8, but recently decreased further to 1.48 in 1998. Thus, the fertility level, as measured by the total fertility rate, has decreased by 75 percent in approximately 40 years.

Table 2-1. Trends in Total Fertility Rate(TFR), 1960~1998

(Unit: per woman)

Year	1960	1974	1984	1987	1990	1993	1996	1997	1998
TFR	6.0	3.6	2.1	1.6	1.6	1.8	1.7	1.56	1.48

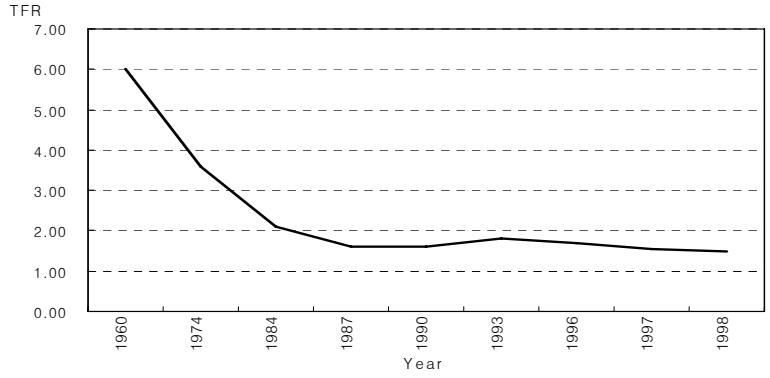
Source: 1) National Statistical Office, *Report on Vital Statistics Based on Vital Registration*, each year.
2) Korea Institute for Health and Social Affairs, *National Fertility and Family Health Survey*, each year.

1) The Korean War was from 1950~1953.

Socio-economic development factors that affect fertility decline include rapid urbanization, increase in educational and economic participation of females, increase in educational attainment of both males and females, and reduction in infant and child mortality rates. Other factors having affected the Korean fertility, no less important than the aforementioned factors, include change in the value or preference for the number of children and/or the family size, change in family structure, including family nuclearization, change in marriage behavior, change in role and function of the family, especially in support for the elderly, etc.

The rapid decline in total fertility rate in Korea is mainly attributed to the successful implementation of the National Family Planning program launched in 1962, which resulted in a high practice rate of contraception; the high population growth in the early 1960's was perceived as an obstacle to national development and hence a national family planning program was adopted as an integrated part of national development planning(Cho, et al., 1995). The contraceptive rate increased form 44.2 percent in 1976 to 70.4 percent in 1985 and 80.5 percent in 1997(see Chapter 3 for details). Socio-economic development, which has facilitated the implementation of national family planning, has been an important contributor to the decline in fertility.

Figure 2-1. Trends in Total Fertility Rate in Korea



For example, the proportion of females aged 20～24 who have attended secondary school or over(see Table 2-2), increased from 13.0 percent in 1960, to 45.0 percent in 1980 and 95.8 percent in 1995. The labor participation rate of females increased from 36.3 percent in 1960, to 42.8% in 1980 and then 48.3 percent in 1995; however, it decreased to 47.0 percent in 1998 due mainly to the impact of the economic recession.

The rise in both educational and economic participation of young females has contributed to the increase in age at first marriage of females, it was 21.6 years in 1960, but continuously increased to 24.1 years in 1980 and 26.2 years in 1998; the recent upward trend in age at first marriage may be attributed to the impact of the economic crisis, which tends to delay marriage of young people. The increase in age of first marriage in Korea has played a more important role in decline in fertility than the decline in fertility rate of married women, since the 1980's (Minja Kim Choe, 1998).

The rapid process of urbanization has also been a major contributor, directly and indirectly, to the decline in fertility, through its affect on other factors such as education and economic participation of females and change in attitude towards the children and family. The proportion of population in Korea who reside in urban areas increased from 28 percent in 1960, to 57 percent in 1980 and to 78 percent in 1995.

Infant mortality is also an important contributor to the decrease of the level of fertility since reduction of the infant mortality rate reduces the necessity for couples to have additional children. The trend in infant mortality rate in Korea has shown a considerable decline from 82.0 infant deaths per 1,000 live births in 1960 to below 10 in recent years. The proportion of the nuclear families to extended families increased from 71.5 percent in 1970 to 79.8 percent in 1995.

Table 2-2. Trends in Socio-economic Factors Affecting the Decline in Fertility, 1960~1998

	1960	1970	1980	1990	1995	1998
Female education[1](%)	13.0	23.5	45.0	88.2	95.8	-
Female LFPR[2](%)	36.3[3]	39.3	42.8	47.0	48.3	47.0
Age at first marriage for females(years)	21.6	23.3	24.1	24.9	25.4	26.2
Urbanization(%)	28	41	57	74	78	-
Infant mortality rate	-	45	17('81)	13('87)	9.9('93)	7.7('96)
Ideal No. of children	-	2.8('76)	2.5('82)	2.1('91)	2.2('94)	2.3('97)
Nuclear families to relative families	-	71.5	72.9	76.0	79.8	-

Note: 1) Proportion of females aged 20~24 who have attended secondary school or over.
2) Labor force participation rate.
3) For 1963, among persons 14 years of age or over.

Source: National Statistical Office, *Population and Housing Census Report*, each year.

National Statistical Office, *Annual Report on the Economically Active Population Survey*, each year.

Korea Institute for Health and Social Affairs, *1998 Health and Welfare Indicators in Korea*, 1998.

OECD, *Health Data*, 1998(for 1970, 1981, 1987).

Ministry of Health and Welfare, Korea Institute for Health and Social Affairs, *Infant Mortality Rate and Causes of Death of 1993 Birth Cohort in Korea*, 1996.

Han, Youngja, et al., *Level and Causes of Infant Mortality and Perinatal Mortality for 1996*, Ministry of Health and Welfare, Korea Institute for Health and Social Affairs, 1998.

Cho, Nam-Hoon, et al., 1997 National Fertility and Family Health Survey Report, Korea Institute for Health and Social Affairs, 1997.

The fertility decline in Korea is also attributed to the increase in proportion of single women and attitude among women that it is necessary to decrease the number of children.

The proportion of women who have never been married(see Table 2-3) increased from 57.3 percent for the 20～24 year age group in 1970, to 66.1 percent in 1980 and 83.3 percent in 1995. There has also been an increase in the proportion of never-married women for the 25～29 and 30～34 age groups. The proportion for the 25～29 age group was only 9.7 percent in 1970 but was 29.6 percent in 1995, showing an increase of about 20 percent points or by 205 percent during this period. There was a 5.3 percent point or 380 percent increase in the proportion of never-married women during the same period.

According to the National Fertility and Family Health Surveys conducted by the Korea Institute for Health and Social Affairs, the proportion of married women who expressed 'having a child(ren) is necessary' decreased from 90.3 percent in 1991 to 73.7 percent in 1997. The ideal number of children which the currently married women expressed changed from 2.8 in 1976 to 2.3 in 1997.

It should be noted that the rapid decline in fertility in 1998 may be attributed to the delay of marriage and delay of and ceasing to give birth because of increase in unemployment and divorce, reduction in income, etc., resulting from the recent economic crisis.

Table 2-3. Trends in Proportion of Single Women, 1960～1997

(Unit: %)

Age	1970	1975	1980	1985	1990	1995
20～24	57.3	62.5	66.1	72.1	80.4	83.3
25～29	9.7	11.8	14.1	18.4	22.1	29.6
30～34	1.4	2.1	2.7	4.3	5.3	6.7

Source: National Statistical Office, *Population and Housing Census Report*, each year.

2) Mortality

In Korea, improvement in nutrition, improvement in health status, change in life style, etc, which are often concomitant with socio-economic development, have played a role in reducing mortality, including infant and maternal mortality rates, thereby resulting in a considerable rise in life expectancy.

Table 2-4. Trends in Life Expectancy at Birth, 1960~1997

(Unit: years)

	1960	1970	1977	1985	1991	1993	1995	1997
Both sexes	52.4	63.2	64.5	68.4	71.7	72.8	73.5	73.4
Male	51.1	59.8	60.8	64.5	67.7	68.8	69.6	70.6
Female	53.7	66.7	68.7	72.8	75.9	76.8	78.4	77.1
Difference	2.6	5.9	8.0	8.3	8.2	8.0	7.8	7.6

Source: National Statistical Office, *1971~1997 Life Tables for Korea,* 1999.
National Statistical Office, *Future Population Projection,* 1996.

Life expectancy at birth(see Table 2-4) was 52.4 years for both males and females in 1960 but increased to 73.4 years in 1997. During the period from 1960 to 1997, life expectancy at birth increased by 19.5 years or 38.2 percent for males, but increased by 23.4 years or 43.6 percent for females. It has often been mentioned that improvement in nutrition and health status due to economic development and reduction in fertility due to family planning have contributed to the reduction of mortality for females, but the reduction in level of male mortality has been less due to exposure to difficult and dangerous work, accidents and social stress, which are often associated with smoking and drinking(Lee, 1991).

B. Change in Population Size and Structure

The population growth rate has declined with the sustained low fertility and mortality of Korea. The growth rate per annum was 1.69 percent between 1960～1970, 1.17 percent between 1970～1980 and decreased to 0.98 percent during the 1990s(see Table 2-5). It is projected that it will be 0.68 percent during the first decade of the new century and 0.34 percent by 2010. A zero population growth rate will be reached in 2028 with a population size of 52.8 million, and thereafter the Korean population will decrease.

As can be seen from Table 2-5, the trend in the number of children(0～14 years old) has continuously decreased; the growth rate per annum was minus 0.57 percent during the 1970s and minus 0.52 percent during the 1990s. Although the working age population(15～64 years old) has increased, the growth rate per annum has decreased rather rapidly. The absolute size of the working age population will start decreasing after reaching its peak(36.5 million) in 2018 as the declining youth population enters working age. The aged population 65 years of age or over has continued to and will increase with a high growth rate of approximately 4 percent per annum, with the increase in life expectancy. The proportion of the elderly will reach 7 percent in 2000, indicating that Korea will become an ageing society. It will double in 2022, resulting in Korea becoming an aged society.

Table 2-5. Changes in Population Size and Age Structure, 1970~2030

(Unit: thousand persons, %)

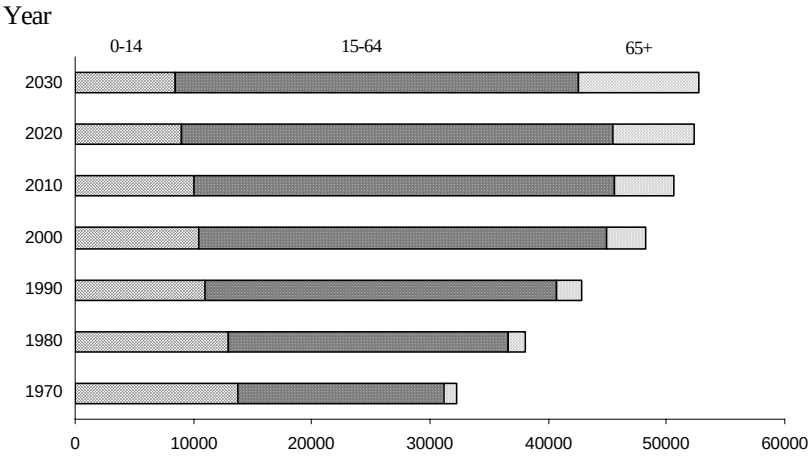
Year	Population	Age Structure		
		0~4	15~64	65+
1970	32,241 (-)	13,709 (-)	17,540 (-)	991 (-)
1980	38,124 (1.68)	12,951 (- 0.57)	23,717 (3.02)	1,456 (3.85)
1990	42,869 (1.17)	10,974 (- 1.66)	29,701 (2.25)	2,195 (4.10)
2000	47,295 (0.98)	10,421 (- 0.52)	34,450 (1.48)	3,371 (4.29)
2010	50,618 (0.68)	10,080 (- 0.33)	35,506 (0.30)	5,032 (4.01)
2020	52,358 (0.34)	9,013 (- 1.12)	36,446 (0.26)	6,899 (3.16)
2030	52,744 (0.07)	8,448 (- 0.65)	34,130 (-0.66)	10,165 (3.88)

Note: 1) The figures in parenthesis denote the population growth rate per annum during the last ten years.

Source: National Statistical Office, *Future Population Projection,* 1996.

However, the total fertility rate decreased further to 1.56 in 1997 and 1.48 in 1998, although the official population projection(National Statical Office, 1996) assumed the total fertility rate would remain 1.7 by 2015 and thereafter increase to 1.8, which would be maintained onwards. Since the other assumptions such as mortality and migration are in accordance with actual change, this study made another population projection assuming the total fertility rate will remain at 1.5 from 2000 and the other assumptions directly applied official projections.

Figure 2-2. Changes in Population Size by Age Group in Korea



(Population in thousands)

The results show that the zero population growth rate can be expected to be reached in 2020 at a population size of 50.0 million, which is earlier than the official estimation. Population ageing will accelerate at an even higher speed; the elderly population will reach 14 percent of the total population in 2021, one year earlier than officially estimated. Change from increase to decrease in labor supply will come 2 years sooner than the officially estimated year of 2018.

Thus, Korea will face accelerated population ageing and lack of labor. Such a change in population structure will eventually cause excessive burden of the working population because of increasing social security expenditures, as can be seen in most developed countries. These problems and the countermeasures taken by the government, in relation to the transition in population dynamics, will be further elaborated upon in subsequent chapters.

C. Socio-economic Development

The economic growth rate in Korea has been maintained at a high level since the early 1960s, with the launching of the economic development plan. The gross domestic product growth rate decreased to -5.8 percent in 1998 due to the economic crisis, which started at the end of 1997(refer to Table 2-6). This high economic growth rate resulted in a considerable increase in per capita gross national income; it was only 79 US$ in 1960, at current prices(per capita gross national produce), but increased to 10,823 US$ in 1995 and 11,380 US$ in 1996(per capita gross national income at current prices)[2]. However, per capita gross national income decreased to 6,823 US$ in 1998 due to the economic recession.

There has been a steady increase in the economic participation rate, which was 55.3 percent in 1963 and increased to 62.0 percent in 1995. However, it decreased to 60.7 percent in 1998. The unemployment rate was very high in the early stage of economic development in Korea but decreased significantly to 2.0 percent in 1995. The exceptions were for 1980 and 1998 which were the oil crisis and recent economic recession periods, respectively.

Specifically, the sharp increase in the unemployment rate in 1998 was due mainly to economic restructuring, after which the rate gradually decreased. In the industrial structure, the employment proportion accounted for by agriculture, forestry, and fishing has rapidly decreased, at 12.4 percent for 1998; the proportion by mining and manufacturing increased continuing up to the early 1990s and thereafter decreased to 19.6 percent in 1998; and the proportion by social overhead capital(SOC) and other services continually increased to 68.0 percent in 1998.

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2) The Bank of Korea produced the per capita GNP(Gross National Product) until 1989, but produced per capita GNI thereafter(Gross National Income).

Table 2-6. Trends in Economic Growth and Employment Structure, 1960~1998

	1960	1970	1980	1990	1995	1998
GDP Growth Rate (at 1995 constant prices)(%)	-	8.5[1)]	6.2[2)]	9.2[3)]	8.9	-5.8[4)]
Per capita GNP/GNI(US$)	79	248	1,597	5,886	10,823	6,823
Economic Participation Rate(%)	55.3('63)	55.9	57.1	60.0	62.0	60.7
Unemployment Rate(%)	8.2('63)	4.5	5.2	2.4	2.0	6.8
Employment Structure by Industry	100('63)	100.0	100.0	100.0	100.0	100.0
Primary(%)	63.1	50.4	34.0	18.3	12.5	12.4
Secondary(%)	8.7	14.3	22.6	27.3	23.6	19.6
Tertiary(%)	28.2	35.2	43.4	54.4	64.0	68.0

Note: 1) for 1971. 2) for 1981. 3) for 1991.
4) Estimates for 1999 by the Bank of Korea.
5) GDP growth rate is based on new SNA for 1990 and ongoing years.
6) Per capita GNP until 1989 and per capita GNI thereafter.

Source: Ministry of Health and Social Affairs, *The Sixth Five-Year Socio-economic Plan(1987~1991): Health and Social Affairs Sector*, 1987.
Economic Planning Board, *Major Statistics of the Korean Economy*, 1981.
National Statistical Office, *Major Statistics of the Korean Economy*, 1999.
National Statistical Office, *Annual Report on the Economically Active Population Survey*, each year.

Rapid recovery from the economic recession has been made since early 1999. According to the Korea Development Institute, the economic growth rate was 7.5 percent in 1999 and will be 6.4 percent in 2000. Such economic growth will increase per capita gross national income to 8,600 US$ and will recover to 10,000 US$ by 2000. The unemployment rate will also decrease from 6.8 percent in 1998, to 6.4 percent in 1999 and 5.4 percent in 2000. The per capita income is expected to reach between 20,000 and 25,000 US$ by 2010. This shift in economy will change the country's focus from overcoming absolute poverty to solving relative poverty, by reinforcing welfare policy such as the "Mid and Long-term Vision of the Economy in Korea: Social Welfare Field"(Ministry of Health and Welfare, 1999).

In Korea, high population growth, which repressed economic growth, was considered to be one of the main obstacles to economic development and, hence, national family planning has been integrated as an important component into Five-Year Economic Development Plan, since 1962. The successful implementation of national family planning, together with socio-economic development, has resulted in a rapid decline in fertility. The reduction in the number of children per family, together with rise in income, increased the resources that could be allocated per child, for example, for education and health, including nutrition.

The improvement in educational level in Korea has been attributed to parents' zeal to educate their children in higher schools, which has been further facilitated by the rise in income and decline in number of children. Since the early 1980s, the enrollment rate in elementary school has been almost 100 percent and the advancement rates from one level of school to a higher level has considerably increased; the advancement rate of elementary school graduates to middle school increased from 49.9 percent in 1963 to over 99 percent since 1990, the advancement rate of middle school graduate students to high school increased 70.1 percent in 1970 to 99.2 percent in 1998, and the advancement rate to college or higher for high school graduates increased from 26.9 percent in 1970 to 84.4 percent in 1998(refer to Table 2-7).

Table 2-7. Trends in Advance Rate by School, 1960~1998

(Unit: %)

	1960	1970	1980	1990	1995	1998
School Advancement Rate						
Elementary school to middle school	49.9('63)	66.1	93.7	99.4	99.4	99.9
Middle school to high school	70.4('62)	70.1	84.6	91.4	96.5	99.2
High school to junior college+	-	26.9	43.3	44.9	74.2	84.4

Note: The enrollment rate for elementary school is almost 100 percent.

Sources: Economic Planning Board, *Major Statistics of the Korean Economy,* 1981.
National Statistical Office, *Major Statistics of the Korean Economy,* 1999.

From Table 2-8, it can be seen that the proportion of people aged 20 or over who graduated from high school or higher, of the total population aged 20 or over, increased from 18.1 percent in 1970 to 63.0 percent in 1995.

Table 2-8. Proportion Having Attended High School or Higher among Persons Aged 20 Years or Over, 1970~1995

	1970	1975	1980	1985	1990	1995
%	18.1	22.1	31.6	42.9	54.0	63.0

Source: National Statistical Office, *Population and Housing Census Report*, each year.

Chapter 3. Reproductive Health

A. Historical Development of Reproductive Health

Since the 1994 International Conference on Population Development(ICPD) held in Cairo, the move from categorical family planning to the broader reproductive health approach has been accelerated in many countries. Generally, reproductive health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Thus, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well being by preventing and solving reproductive health problems(UN, 1995: ICPD Programme of Action, para 7.2).

As defined by the ICPD Programme of Action, reproductive health care, in the context of primary health care, includes family-planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family-planning services and further diagnosis and treatment for complications of pregnancy, and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including STD and HIV/AIDS should always be available when required.

Although many countries have initiated a new concept of reproductive health, less has been accomplished in implementing integrated reproductive health programs, mainly due to lack of integrated reproductive health interventions, program budget, and qualified health personnel.

In Korea, the national family planning program, as a major means of population control policy, has been a key element in reproductive health programs since 1962. This program includes the demographic target of reducing the annual population growth rate and the total fertility rate, and it was vigorously implemented as a categorical program through the successive five-year economic development plans. The main reasons for adopting the categorical family planning approach were: 1) the urgency of the population problem required that family planning be given priority over other health programs, such as tuberculosis control and maternal and child health: 2) development of the maternal and child health program in Korea was in an infant stage, and it would have taken too much time and cost to develop: 3) the maternal and child health program would have claimed the majority of the limited available budget(Yang, 1991) and would have slowed down the progress of the family planning program that had so far been achieved. The strength of this categorical family planning program lies in its limited goals, the acquisition of resources and the building of an organizational process specifically for the demographic goals. Also, commitment to family planning goals led to development of extensive linkages with other sectors such as the mass media, and private practitioners' clinics and hospitals.

However, starting in the late 1970s contraceptive acceptance had attained a plateau at 44 percent(Cho, 1986) and the added family planning input was not commensurate with its output. The new government of the Fifth Republic, therefore, began to look into the possibility of integrating maternal and child health with family planning in order to further strengthen the population control program as a part of the Fifth Five-Year

Economic and Social Development Plan(1982～1986), which emphasized social aspects, and was aimed towards attainment of the welfare state by the year 2000(Economic Planning Board, 1981). In 1981 the government focused attention on the impact of population growth on the nation's socio-economic development for the immediate future and accordingly, strengthened population control policy measures. Policy changes were made in organization, personnel and resource allocation for integration of maternal and child health with the on-going family planning program. These changes included the integration of individual family planning, maternal and child health, and tuberculosis workers into multipurpose health workers, and the revision of the Maternal and Child Health Law to strengthen both maternal and child health and family planning programs.

As a result of these efforts by the government in increasing population control programs, fertility took a drastic downturn in the 1980s. In 1988 the national family planning program in Korea achieved its primary objectives of reducing the fertility rate to below the replacement level and accomplishing near universal contraceptive use. As a result, when the 7th Five-Year Economic and Social Development Plan(1992～1996) was drawn up in 1991, the government began to move away from its policy on free contraceptive distribution through government programs toward a self-paid system, administered by private and commercial sectors, such as the nationwide health insurance program.

Nevertheless, no sooner was one set of problems overcome than new challenges of a totally different nature arose out of the resulting decreased fertility rate. Some of the unfavorable consequences of rapid fertility decline in Korea include an unbalanced sex ratio, an increase in the elderly population, and a high prevalence of selective abortions. In order to deal with these new problems, it became apparent that Korea would have to shift its population policy directions in a way that best

reflected the changing socio-economic and demographic conditions currently being witnessed and forecast for the immediate future.

For this purpose, the government established a Population Policy Deliberation Committee in December 1994 to review population policy by focusing on its past accomplishments and future prospects, as well as related socio-economic problems, in an effort to work out new policy directions and measures for the 21st century. During that process, major objectives of the ICPD recommendations and Programme of Action were also reviewed and reflected in the policy formulation. In 1996, the government officially adopted new population policy with emphasis on reproductive health care services. In spite of this policy action by the government, however, there are still many issues to be solved, such as integrating reproductive health services, setting priorities, creating linkages among the different elements of reproductive health, and financing comprehensive reproductive health.

With the new population policy, the family planning program played a crucial role once again, and its major anticipated shifts in policy and directions for the immediate future were; 1) to enhance the quality of contraceptive services to reduce the induced abortion prevalence rate, 2) to integrate reproductive health programs, such as family planning, maternal and child health and other social welfare programs, 3) to strengthen social and institutional support policies for a balanced sex ratio through improvement of women's social status and gender equality; and 4) to expand the scope of the FP program target population to cover the young unmarried population, to prevent premarital pregnancy. The population policy development in Korea can be outlined as follows;

《Highlights of Population Policy Developments in Korea》

Year	Policy developments
1961	- Adopted the National Family Planning(FP) programme policy as part of the Five-year Economic Development Plans in 1992 - Adopted the FP slogan "Have a few children and raise them well"
1962	- Initiated the FP program - Established the FP counseling room and assigned a FP worker to each of the public health centers - Introduced vasectomies, condoms and jelly into the FP program
1964	- Introduced IUD - Began to utilize FP mobile teams in remote areas
1966	- Introduced the FP target system
1968	- Organized the FP Mothers' club - Introduced oral pills
1971	- Established the Korean Institute for Family Planning(KIFP) - Adopted the FP slogan "Stop at two children, regardless of gender"
1973	- Enacted the MCH Law legalizing induced abortions for medical reasons and allowing paramedical IUD insertion
1974	- Initiated special urban FP projects(hospitals, industrial sites, urban low-income areas, population education) - Introduce MR services - Income tax exemption for families with up to 3 children
1976	- Established the Korean Health Development Institute(KHDI) - Introduced female sterilization - Established the Population Policy Deliberation Committee - Assigned male information officers in 138 county health centers
1977	- Income tax exemption for up to 2 children - Corporation tax exemption on expenditures for FP services given to employees - Revision of the Family Law on women's inheritance of property
1978	- Priority in allotting public housing given to sterilization acceptors with less than 3 children - Adopted FP slogan " A well bred girl surpasses ten boys"

(Continued)

Year	Policy developments
1980	- Granted discounts in child delivery charges for sterilization acceptor after second delivery, in public hospitals
1981	- Adopted new innovative population policy to place greater emphasis on social support policies and activation of the FP program - Upgraded health workers to regular health officers - Formed the Korea Institute for Population and Health(KIPH) through the merger of KIEF and KHDI
1982	- Sterilization and IUD services provided through the medical health system. - Priority given to sterilization acceptor with 2 or less children, for housing loans and livelihood loans of the low-income group - Monetary subsidies to low-income sterilization acceptor to compensate for lost wages(US$ 140 for those with 2 or less children and US$ 40 for those with 3 or more) - Primary medical services for children up to 5 years old free of charge to sterilization acceptor with 2 or less children - Tax exemption on education allowances to government employees with up to 2 children(enforced in 1983)
1983	- Introduction of newly developed IUDs such as Copper T
1985	- Expansion of health insurance coverage to married females' parents and married workers' parents-in-law - Integrated individual FP, MCH and TB workers into health workers in rural areas
1986	- Shift of contraceptive strategy from sterilization to reversible methods for age group in their 20's
1987	- Revision of the Medical Law to forbid prenatal sex identification
1989	- Gradual shift from contraceptive services free of charge through government support to self-support contraceptives of users through health insurance programme and commercial sector - Revision of the Family Law for daughters' right to be household head and receive equal share of inheritance - KIPH was renamed the Korea Institute for Health and Social Affairs(KIHASA)

(Continued)

Year	Policy developments
1994	- Revision of the Medical Law to strengthen punishment for medical personnel who provide prenatal sex identification(3 years or less imprisonment and US$ 12,500 or less fine)
1996	- Adoption of the New Population Policy with emphasis on population quality and welfare

Source: Cho, Namhoon, *Achievements and Challenges of Population Policy Development in Korea,* Korea Institute for Health and Social Affairs, 1996.

B. Family Planning and Maternal and Child Health

1) Family Planning

The spread of the small-size family norm among women of reproductive age has helped increase the recent contraceptive practice rate to a saturation point, since effective contraceptives enable women of reproductive age to choose when and how many children they wish to have, and thus serve as efficient reproductive health "devices".

In Korea, the contraceptive practice rate(Table 3-1) increased from 44.2 percent in 1976 to 77.1 percent in 1988. This high practice rate indicated that almost all persons in need of contraception had accepted it. Therefore, since 1989 the government has shifted the distribution of contraceptive services from government supported programs to self-support programs, through the health insurance system and private sector. As can be seen from Tables 3-2 and 3-3, the contraceptive services supported by the government and government budget for family planning declined rapidly after the mid-1980s.

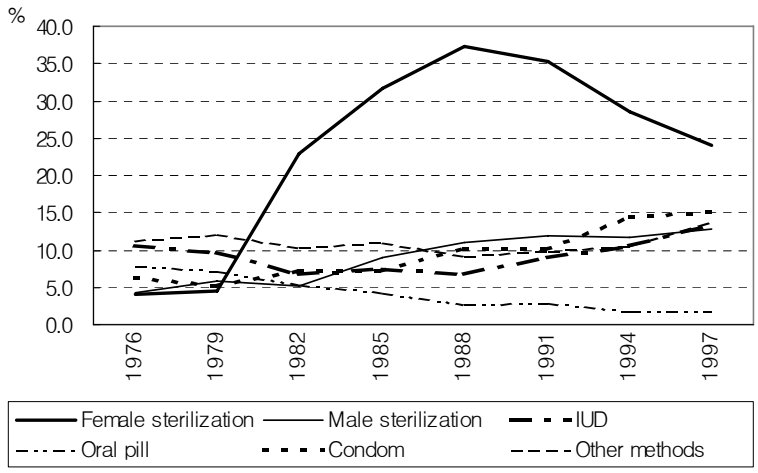
Table 3-1. Contraceptive Practice Rates of Currently Married Women, by Method, 1976~1997

(Unit: %)

Methods	1976	1979	1982	1985	1988	1991	1994	1997
Female sterilization	4.1	4.5	23.0	31.6	37.2	35.3	28.6	24.1
Male sterilization	4.2	5.9	5.1	8.9	11.0	12.0	11.6	12.7
IUD	10.5	9.6	6.7	7.4	6.7	9.0	10.5	13.2
Oral pill	7.8	7.2	5.4	4.3	2.8	3.0	1.8	1.8
Condom	6.3	5.2	7.2	7.2	10.2	10.2	14.3	15.1
Other methods	11.3	12.1	10.3	11.0	9.2	9.9	10.6	13.6
Total	44.2	54.5	57.7	70.4	77.1	79.4	77.4	80.5

Source: Cho, Nam-Hoon, et al., *1997 National Fertility and Family Health Survey Report*, Korea Institute for Health and Social Affairs, 1997.

Figure 3-1. Changes in Contraceptive Practice Rates by Method



Despite such rapid decreases in budget appropriated for family planning and government supported contraceptive services, the contraceptive practice rate increased to 80.5 percent in 1997. This shows that family planning has become a social norm in Korea.

In 1997, women in the 35～39 year age group show the highest contraceptive practice rate with 91.1 percent, followed by those in the 40～44 age category with 89.6 percent. Female and male sterilization accounted for 46 percent of the total practice rate in l997. Thus, family planning needs to be emphasized for women in their twenties who are more likely to accept contraceptive methods to control birth intervals and to adolescents whose unwanted pregnancies often result in threatening of their reproductive health and other social problems.

Table 3-2. Government Contraceptive Services by Year, 1962～1999

(Unit: thousand)

Year	IUD	Vasectomy	Tubectomy	Condom[1)]	Oral Pill[1)]
1962	-	3.4	-	59.4	-
1963	1.5	19.9	-	129.8	-
1964	106.4	26.3	-	156.3	-
1965	226.0	12.9	-	191.7	-
1966	391.7	19.9	-	168.9	-
1967	323.5	19.7	-	152.7	-
1968	263.1	16.0	-	135.2	26.3
1969	285.5	15.5	-	147.8	91.2
1970	295.1	17.3	-	163.0	170.5
1971	293.7	18.6	-	161.3	199.7
1972	299.9	16.4	3.3	155.6	214.0
1973	325.9	19.7	4.8	176.0	234.7
1974	351.6	32.0	5.3	172.7	242.0

(Continued)

Year	IUD	Vasectomy	Tubectomy	Condom[1)]	Oral Pill[1)]
1975	343.9	43.1	14.5	196.7	240.2
1976	297.9	44.9	35.6	158.0	203.4
1977	281.8	53.8	181.5	103.2	178.9
1978	240.9	36.9	193.4	110.9	130.5
1979	188.7	25.9	195.3	80.8	108.8
1980	188.4	28.0	179.1	73.8	102.8
1981	167.2	31.3	164.8	79.0	91.4
1982	199.1	53.1	233.5	101.6	113.0
1983	213.1	97.2	329.9	127.3	82.4
1984	195.4	123.2	255.6	129.7	59.2
1985	176.9	110.1	217.6	124.9	44.0
1986	233.4	92.2	220.3	108.3	45.8
1987	242.5	83.0	211.9	144.2	39.3
1988	251.9	70.9	165.9	137.8	29.3
1989	235.9	66.2	115.6	144.0	29.4
1990	186.6	45.4	68.1	102.6	20.3
1991	149.5	31.8	36.6	90.3	6.5
1992	145.4	33.1	27.2	100.2	5.7
1993	84.0	26.2	15.8	68.1	5.4
1994	52.0	19.5	8.8	23.5	4.9
1995	34.9	14.5	5.4	13.9	4.2
1996	28.0	12.3	3.6	25.2	3.0
1997	22.6	6.6	2.0	15.0	2.0
1998	18.4	5.1	1.4	11.5	1.5
1999	17.2	5.1	1.1	8.8	0.5

Note: 1) Monthly average of condom and oral pill users.
Source: Ministry of Health and Welfare, *Yearbook of Health and Welfare Statistics*, each year.

Table 3-3. Government Budget for FP and MCH Programmes by Year, 1975~1999

(Unit: Million Won)

Year	Health	FP	MCH	Won per US$
1975	6,422	834	97	484
1980	64,783	8,457	988	660
1981	79,582	8,709	5,240	701
1982	93,267	9,826	12,953	749
1983	115,238	20,532	12,253	796
1984	114,649	22,227	9,981	827
1985	134,135	30,237	2,794	890
1986	157,483	31,760	2,975	861
1987	175,802	27,599	4,240	792
1988	179,798	26,767	4,273	684
1989	193,683	22,026	3,554	680
1990	201,735	10,932	3,158	716
1991	226,693	9,459	4,157	761
1992	196,519	7,563	4,363	788
1993	208,755	5,644	4,632	808
1994	232,135	4,515	4,703	789
1995	229,230	3,618	4,776	775
1996	265,048	2,358	2,765	844
1997	285,116	1,960	4,289	1,415
1998	304,572	1,652	3,746	1,208
1999	389,678	382	6,266	1,185[1)]

Note: 1) As of Aug. 1999.
Source: Ministry of Health and Welfare, *Unpublished Data.*

After the introduction of Intra Uterine Devices(IUD's: Leppe's Loop) by the government as a major principal method into

national family planning programme in 1964, the IUD practice rate reached 10.5 percent in 1976 but decreased to 6.7 percent in 1988. Recently, the rate gradually increased to 13.2 percent in 1997. The IUD method has been gradually replaced by the newly developed products such as Multi-load and Nova-T, since 1982. Copper T. Recently, the government approved the import of the newly developed MIRENA(Levonorgestrel Intra Uterine System) for use by private sector clinics. The practice rate of oral pills plunged from 7.8 percent in 1976 down to 1.8 percent in 1997, indicating that contraception is no longer considered to be only the woman's responsibility in Korea.

Recently, the condom practice rate more than doubled during the same period of time. "Female methods" are slowly giving way to "male methods," an indication that contraception in this country is no longer exclusively women's business. The increase in condom usage is not limited to Korean society alone, nor is the increasing condom usage an indication that contraception is getting "transformed into" a male business, since condoms are increasingly used by single women to prevent transmission of sexually transmitted diseases(STD), including the acquired immuno-deficiency syndrome(AIDS).

In 1997, 71.4 percent of married women said that they had adopted contraception for pregnancy termination, and only 7.5 percent were found to have adopted contraception for birth-spacing, while the remaining 1.6 percent reported they had adopted contraception for other purposes. As for the cost of contraceptive services in 1997, 57.5 percent of all female sterilization acceptors were supported by the government, while female sterilization services through government support[3] covered 74.9 percent of total female sterilization acceptors in 1994. A

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3) Since 1976, when the government introduced female sterilization into the national family planning program, it has supported acceptors, through such methods as giving priority in allotting public housing(1978), reduction in child delivery, etc.

similar situation was seen in male sterilization services; in 1997 68.5 percent of total male sterilization acceptors received government support, while it was 76.7 percent in 1994.

In contrast, in 1997, 93.5 percent of condom users and 95.0 percent of oral pill users purchased their contraceptives through commercial channels. That is, not only condom and oral pill users, but sterilization acceptors are also gradually changing from government support to commercial channels for better contraceptive and reproductive health services. Starting in 1982, sterilization services became covered by the medical insurance scheme, however, in 1997, 14.0 percent of female sterilizations and only 8.3 percent of male sterilization acceptors received services under the medical insurance scheme.

Those who urgently need improved reproductive health services are the men and women who suffer from unplanned and unwanted pregnancies and abortions due to the inadequate quality of family planning information and services available. It could be said that, in Korea, where the contraceptive practice rate has already reached a plateau, that the unmet need group may not be a major problem, however, in a 1997 national survey, 11.5 percent of 5,417 women aged 15～44 years were not practising any form of contraception, even if exposed to risk of pregnancy. Of the 11.5 percent exposed to risk of pregnancy, 8.0 percent were either deliberately not using contraception to have a child or were in the post-partum period; and therefore, over three percent of the 5,417 respondents in the 1997 national survey were those of the unmet need group.

Those women in this unmet need group, however meagre percentage-wise, are in the most disadvantaged category, namely those in the low-income, low-level education category, and reproductive health services for this special target group need to be strengthened. Moreover, the current family planning services need to be expanded for this special group of women to cover broader issues of reproductive health as a whole, including

maternal and child health care, family welfare, as well as the reproductive rights of women.

2) Maternal and Child Health

In Korea, the maternal and child health program has been active since the promulgation of the Maternal and Child Health Law in 1973, which legalized induced abortions under certain conditions for medical reasons and allowed paramedical intra uterine device insertion. In efforts to integrate the maternal and child health program, family planning and other primary health programs, the government integrated individual family planning, maternal and child health and tuberculosis workers in health centers into health workers since 1985.

Table 3-4. Trends in Institutional Delivery, by Institution, 1985~1997

(Unit: %)

	1985	1988	1991	1994	1997
Institutional delivery	75.8	87.8	98.1	98.8	99.7
a) general hospitals	17.8	23.6	-	31.8	39.0
b) clinics	45.8	53.4	91.0	64.4	59.3
c) midwiferies	9.1	7.4	5.1	2.0	1.1
d) health centers	2.5	3.4	2.0	0.6	0.3
Non-institutional delivery	24.8	12.2	1.9	1.2	0.3
Total	100.0	100.0	100.0	100.0	100.0
(N)	(3,541)	(2,843)	(2,151)	(1,932)	(1,163)

* includes general hospitals.

Source: Cho, Nam-Hoon, et al., *1997 National Fertility and Family Health Survey Report*, Korea Institute for Health and Social Affairs, 1997.

Under the 1986 revised Maternal and Child Health Law, expectant mothers are required to apply for the maternal and child health booklet containing the checklist on maternal health status and that of the new-born baby as soon as they become

pregnant; the aim is to record the health status of the mother and child before and after delivery and to thereby prevent probable health problems and provide them with appropriate medical services. A recent Korea Institute for Health and Social Affairs study(Hwang, 1998) shows that 92.5 percent of women who received pre-natal care did bring the maternal and child health booklet on their visits to maternity wards, an increase from 86.9 percent in 1994(see Table 3-2).

The government has included compulsory screening tests for high-risk mothers and/or couples in maternal and child health, since 1991, in order to prevent congenital birth defects and to protect maternal health through early detection. In an effort to expand the rate of screening tests, free tests have been provided to high-risk mothers and free treatment for defective births were provided for poor women, since 1995. In 1997, screening tests were provided at all births free of charge. As a result, the rate of screening tests increased from 35.7 percent in 1994 to 73.6 percent in 1997.

The percentage of women who have visited maternity hospitals or local health centers for pre-natal checkups has been constantly increasing from 82.4 percent (92.1 percent in urban, 78.1 percent in rural) in 1985 to 99.6 percent (99.6 percent in urban, 99.3 percent in rural) in 1997. As for post-natal care, the percentage of women with new-borns that visited maternity hospitals increased from 52.3 percent (57.5 percent in urban areas, 37.31 percent in rural areas) in 1988 to 81.0 percent (81.7 percent in urban areas, 77.8 percent in rural areas) in 1997.

According to the 1997 national survey, 99.7 percent of all new-borns were delivered in an institutional setting, which is a great contrast to the 8.5 percent institutional delivery rate in 1974. In 1980, only 56.9 percent of babies were delivered in maternity hospitals, clinics, and health centers. The reason for this increasing rate of institutional delivery has to do with the

national health insurance system, which has covered the whole population since 1989. Under the insurance system, institutional delivery costs are covered by insurance.

In 1997, among women who had given birth after 1995, only 14.1 present breastfed, while 33.4 percent bottlefed. The remaining 52.5 percent alternated between breastfeeding and bottlefeeding. In 1985, among women who had given birth in the last five years, 59.0 percent breastfed, but since then the proportion breastfeeding has decreased to 48.1 percent in 1988, and down to 11.4 percent in 1994. However, the proportion of bottlefeeding has been on a constant increase from 15.6 percent in 1985 to 18.0 percent in 1988, and again to 27.9 percent in 1994.

In the above mentioned 1997 national survey, 56.1 percent of 979 women who had stopped breastfeeding replied that they had stopped breastfeeding for maternal health reasons. The survey results though, did not include the specific items that impair maternal health. To encourage breastfeeding, maternity hospitals and health centers need to increase Information, Education and Communication activities and campaigns advertising the advantages of breastfeeding for maternal and child health.

The so-called "baby-friendly hospital initiative" needs to be enforced at maternity hospitals to improve the current low level of breast-feeding. Maternity ward facilities need to be rearranged so that both the mother and new-born baby can stay in the same room to breast-feed. A neonatal intensive care unit should be introduced at all maternity hospitals for quality care services. To do so, in 1999 the government(Ministry of Health and Welfare) initiated a three-year demonstration project(1999～2001) on improvement of maternal and child health, centered on 23 public health centers of the total 243 centers across the nation. One of the aims of the demonstration project is to develop a comprehensive reproductive health program. A

Ten-Year Maternal and Child Health Plan is being established for the first decade of the 21st century, to expand the target population to all women and children through health promotion by life-cycle, which is a shift from the target population of infants and pregnant women in the previous years. This plan also aims to promote adolescents' reproductive health and to prevent and cure diseases which are characteristic of middle and old-aged women.

C. Induced Abortion and Pregnancy Wastage

ICPD recommendations urged all governments to reduce abortions through expanded and improved family planning services. Also, in the Fourth World Conference on Women held in Beijing in 1995, all governments were urged to recognize and deal with the health impact of unsafe abortions as a major public health concern. In Korea, under the Maternal and Child Health Law, promulgated in 1973, induced abortions are allowed within 28 weeks from the date of conception in the following cases: (a) possibility of fetal impairment(eugenic grounds), (b) infectious diseases of the parent(s), (c) rape or incest, and (d) impairment of the mother's physical and mental health.

Table 3-5. Number of Induced Abortions of Ever-married Women in Korea, 1975~1996

(Unit: women)

Year	1975	1984	1990	1996
Number	510,072	495,127	403,228	230,062

Source: Cho, Namhoon, et. al., *Recent Population Dynamics and Future Policy Directions*, KIHASA, 1998.

The number of induced abortion cases for ever-married women has considerably decreased, as seen in Table 3-3. The

induced abortion rate has been increasing since the start of the family planning program by the government in 1962. As the data in Table 3-4 indicates though, the rate for women aged 20-24 reached a plateau in 1990 and has since been decreasing. The induced abortion rate for this age group in 1996 is almost half that for 1990. This decline is more pronounced for the period from 1990～1996 for the 20～24 and the 25～29 age groups.

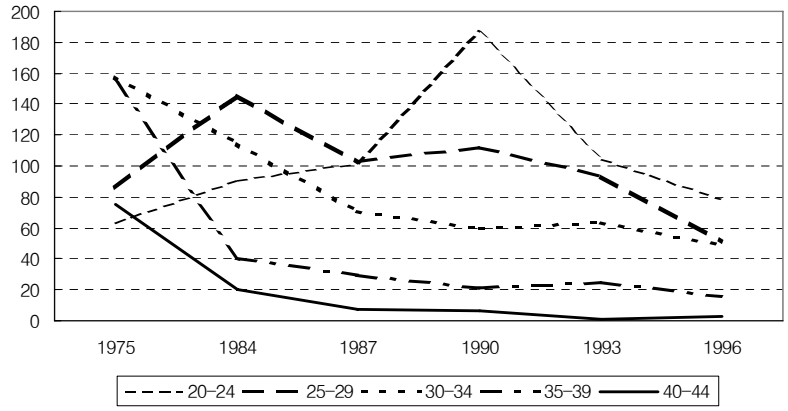
Table 3-6. Changes in Induced Abortion Rates, 1975～1996*

Age category	1975	1984	1987	1990	1993	1996
20～24	63	91	102	186	105	79
25～29	86	146	103	112	94	51
30～34	158	115	71	60	63	49
35～39	153	40	29	21	25	16
40～44	75	20	7	6	1	3
Total abortion rate	2.7	2.1	1.6	1.9	1.4	1.0

Note: this is the number of abortions per 1,000 married women.
Source: Cho, Nam-Hoon, et al., *1997 National Fertility and Family Health Survey Report*, Korea Institute for Health and Social Affairs, 1997

Figure 3-2. Trends in Age-Specific Induced Abortion Rates in Korea

(%)



Notwithstanding the pronounced decline for the young 20～29 age group over the seven-year period, in 1996 the number of abortions in the 20～24 age group accounted for approximately 40 percent of total abortions for the entire 20～44 year age category for that year, while in 1993, the number of abortions in the corresponding age category accounted for only 36 percent of the entire 20～44 age category. That is, even though the rate for the 20～24 year age category decreased by a substantial amount from 1993 to 1996, a greater proportion of abortions have still been, in recent years, concentrated within this particular age group.

Table 3-7. Percentage Distribution of Married Women Who Have Experienced Induced Abortion, by Reason, 1994 and 1997

(Unit: %, persons)

Reasons	1994	1997
Child unwanted	58.4	49.7
Birth-spacing	11.1	11.0
Health of mother	9.7	10.6
Fetal impairment	5.1	3.6
Pre-marital pregnancy	3.3	4.0
Family discord	1.7	1.9
Economic reasons	3.7	7.3
Sex pre-selection(daughter)	1.7	2.6
Other	5.3	9.3
Total	100.0	100.0
(N)	(2,541)	(2,394)

Source: Cho, Nam-Hoon, et al., *1997 National Fertility and Family Health Survey Report*, Korea Institute for Health and Social Affairs, 1997.

Two factors account for the greater concentration of abortions

in the 20～24 age group. One has to do with a lower family planning practice rate in the group. The practice rate for this age category is approximately 50 percent, a level far lower than the national contraceptive practice rate of 80.5 percent. The other has to do with the fact that, unlike women in other categories, a larger number of those in this 20～24 age group favor such unreliable contraceptive methods as condoms and the rhythm method. As for the reasons for induced abortion(Table 3-5), from the 1997 National Fertility and Family Health Survey(Korea Institute for Health and Social Affairs, 1997), 49.7 percent of married women who experienced induced abortion replied that they had to resort to abortion because they do not want children, and 11.0 percent said they had the abortion for birth-spacing.

Table 3-8. Pregnancy Outcomes for Married Women Aged 15～44, 1994～1997

(Unit: %, persons)

Pregnancy outcomes	1994	1997
Full-term parturition	61.0	62.9
Pregnancy wastage	36.9	35.5
a) still birth	(0.4)	(0.3)
b) spontaneous abortion	(8.2)	(9.1)
c) induced abortion	(28.3)	(26.1)
Currently pregnant	2.1	1.6
Total(N)	100.0(15,316)	100.0(15,311)

Source: Cho, Nam-Hoon, et al., *1997 National Fertility and Family Health Survey Report,* Korea Institute for Health and Social Affairs, 1997.

In Korea, the average number of pregnancies decreased from 3.5 in 1991 to 2.8 in 1997. In 1991, 44.9 percent of 7,462 married women aged 15～44 had experienced more than four

pregnancies, whereas, in 1994 31.7 percent of 5,183 women of the same age category had the same number of pregnancies. In 1997, only 29.2 percent of 5,418 women of the same age group had more than four pregnancies.

The decrease in the number of pregnancies, inter alia, has to do with the continuing fall in infant mortality rate, the prevalence of contraceptive use among women of childbearing age, and with the sustained socio-economic development of the country. As for pregnancy wastage, Table 3-7 indicates that maternal health, as far as pregnancy wastage is concerned, has gradually improved, at least for the last couple of years. However, more than 35 percent of 1997 pregnancy outcomes are accounted for by pregnancy wastage, and most of the pregnancy wastage is due to induced abortions. Unsafe abortion, along with hemorrhage, obstetrical labor, infection, and pregnancy-induced hypertension, is one of the five main causes of maternal death. The fact that a large portion of the pregnancy wastage results from induced abortions points to the urgent need to come up with measures to reduce induced abortions.

The three-year demonstration project(1999～2001) on improvement of reproductive health, centered on 23 public health centers of the total number of 243 centers in the nation, aims to improve reproductive health, including maternal and child health, of women of childbearing age, specifically adolescents. This project will be expanded to the whole country after project results are produced.

D. Adolescent Sexual Behavior

1) Status of Adolescent Sexuality

In Korea, with the centuries-old Neo-Confucian mores unraveling at its seams in the last couple of decades, adolescent sexuality, which often leads to teen-age pregnancy, has emerged as a serious social problem. For instance, a 1992 study(Korea

Institute for Criminal Policy, 1992) of students in middle, high, and vocational schools, and of adolescent residents in two borstals institutions revealed that 5.5 percent of 3,611 third-year middle school students, 15.4 percent of 3,756 third-year high school students, 37.7 percent of 777 vocational school students, and almost two-thirds of 255 adolescents in borstals institutions reported having had sexual intercourse at least once.

A report from the Ministry of Health and Welfare and a non-governmental organization[4] records a total of 6,734 abandoned children from unwed mothers in 1997. The ministry estimated that there were 7,000 unwed mothers for that year. These unwed mothers are at risk and hard-to-reach for reproductive health. More surprisingly, the proportion of teenagers among unmarried mothers who received care from Unmarried Mothers' Protection Institutions[5], increased from 24.3 percent in 1991 to 32.4 percent in 1993 and 47.9 percent in 1997(Lee, 1998).

The National Fertility and Family Health Survey(Korea Institute for Health and Social Affairs, 1997) indicates that the proportion of ever-married women who accepted induced abortion due to pre-marital conception has increased, although it is comparably lower than other reasons. This survey result implies that many adolescents' pregnancies are wasted by induced abortions. In the absence of knowledge on contraceptives and of adolescents' willingness to resort to contraceptive methods, even if contraceptives are easily accessible to them, adolescent sexuality is most likely to end up in teen-age childbearing. Their pre-marital pregnancy often leads to pregnancy-related complications resulting from unsafe induced abortion. Adolescents often have no choice but to resort to unsafe abortion to avoid leaving school. Unmarried women are more likely to seek abortions from untrained hands, often because of fear, shame, and lack of money, and to delay

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4) Planned Parenthood Federation of Korea, A Ten-Year Plan for Maternal and Child Health program, (Dec. 1998), p.33.
5) As of 1999, there were 8 institutions.

seeking medical care for abortion complications.

2) Countermeasures and Constraints

Sex education in Korea has been strengthened with the increase in sexually active adolescents. Sex education in Korea can be classified into school education and social education. Social sex education has been provided mainly through non-governmental organizations, which include the Planned Parenthood Federation of Korea and other non-governmental organizations related to youth and females. Specifically, Planned Parenthood Federation of Korea established the Korea Culture and Sexuality Research Center in 1996, where they perform research on sexual activity, develop materials for sex education and pursue awareness activities. As of 1998, the Planned Parenthood Federation of Korea operated 12 "adolescents' counseling offices" and designated 31 middle and high schools nationwide as "sex education collaboration schools" to develop a systematic model for sex education in schools. It also provides training for sex-education professionals. Much legal effort has been made to protect adolescents from sexual abuse and violence; for example, the Punishment of Sexual Violence and Protection of Victim Act and the Law for Protection of Adolescents were enacted respectively, in 1994 and 1991.

In Korea, the goal of sex education is to make a person aware of ethical and moral norms, conjugal rules, and life values related to sex by teaching the value and necessity of sex, and ecological norms of sex and how they are concerned with the reproduction of living organisms. Thus, the purpose of sex education is to ensure: (1) that growing children and adolescents form their own identity and trust regarding sexuality as well as have completely mature sexual functions by teaching the developmental process of sex; (2) they understand the characteristics and roles of human sexuality and lead a healthy life suitable to one's relations, lifestyle, and

social standards on the basis of reciprocated confidence, respect, and cooperation; (3) systematically and scientifically obtain sexual information in order to obtain strong social relations based on the physiological structure and function of both men and women, psychological characters and roles, equality, confidence, esteem, and cooperation; and (4) possess appropriate sexual knowledge based on a mature life style, and systematic and scientific knowledge of sex and then to build up sexual morality.

However, in elementary school, teachers instruct passive knowledge about sex on a biological level in the subjects of physical education, ethics, and nature to 5th and 6th grade students. In middle school, teachers teach common contents concerning the structure of human body and physical change in the subjects of physical education, morality, science, home economics, etc. Also, they teach female physiology and physical characteristics in home economics classes for girls. In high school, human sexuality and housekeeping are instructed in physical education, national ethics, science, etc,. Also, pregnancy, delivery, and childcare, as part of sex education, are mostly dealt with in home economics. Thus, sex education is limited to the theoretical biology of the physical structure and school curriculum does not include independent subjects concerning sex education, but it is spread out in several related subjects.

Educational materials on teenage sexuality and youth reproductive health should be developed for use at various levels in schools. Currently, adolescent sex education is being conducted by four separate government ministries: the Ministry of Education, the Ministry of Labour, the Ministry of Health and Welfare, the Ministry of Government Administration and Home Affairs, and the Ministry of Culture and Tourism. Teenage sex education needs to be unified under a single government administration. In addition, the Committee for Adolescents, which consists of 12 ministers and 14 experts, need to be strengthened to address and prevent sex problems

and drug abuse. The committee need also be made responsible for the coordination and development of integrated policies and programs to address the needs of adolescents.

E. Sexually Transmitted Diseases(STD) and Acquired Immunodeficiency Syndrome(AIDS)

1) Status of STD

According to registration statistics, the number of sexually transmitted disease infected people in Korea decreased from 53,400 in 1996 to 49,446 in 1997(Table 3-7); the majority of sexually transmitted disease infected people were female pink collar workers. However, if the infected not registered in the government's registry are taken into account, then this number becomes considerably greater. They are mostly concentrated into the age group 20～29. The female infected are prevalent among women in their 50's and 60's, whereas the male infected are prevalent among men in their 20's and 30's(Korean Anti-AIDS Federation, 1999).

The government has made efforts to curb the spread of HIV/AIDS, since 1985. Sexually transmitted diseases are designated as third-class communicable diseases by the Infectious Diseases Prevention Act. Following this Act, waitresses working in bars must register themselves in the government registry and receive regular inspections. If they are infected, they are to leave work and receive treatment. Before the national health insurance scheme, public health centers provided free-diagnoses under the Sexually Transmitted Disease Medical Care Act.

However, revision of the enforcement ordinance in 1998 excluded sexually transmitted disease patients and the vulnerable from medical insurance benefits, which has resulted in a lowered rate of sexually transmitted disease treatment and difficulties in preventing sexually transmitted disease infection

of the vulnerable groups. The number of sexually transmitted disease diagnosis centers increased to 557 by 1998. However, since a number of pink collar workers are not registered and have high propensity for migration, it is difficult to supervise sexually transmitted disease patients, although the sexually transmitted disease infected need to be detected and treated throughly to prevent AIDS transmission.

Table 3-9. Trends in the Number of Sexually Transmitted Disease Infected People, 1996 and 1997

(Unit: persons)

	Gonorrhea	Syphilis	Non-gonorrheal Urethras	Others	Total
1996	7,722	10,053	26,222	9,403	53,400
1997	7,914	9,915	26,134	5,503	49,466

Source: Korean Anti-AIDS Federation (KAAF), *Newsletter, February* 1999.

2) Status of HIV/AIDS

In Korea, the first HIV positive case was reported in December, 1985, and the first AIDS case in February 1987. The number of HIV positive infected has continuously increased to reach a total of 1,014 in September of 1999(refer to Table 3-8). The total 1,014 infected is composed of 882 males and 132 females, and of them 224 have already died of AIDS.

Table 3-10. Trends in HIV Infected People, 1985~1999

(Unit: persons)

	Total	1985~92	1992	1993	1994	1995	1996	1997	1998	1999
Total	1,014	169	76	78	90	108	102	124	129	138
Male	882	146	72	71	78	89	90	107	111	118
Female	132	23	4	7	12	19	12	17	18	20
Patients	158	8	2	6	11	14	22	33	35	27

Source: National Institute for Health, *News report data,* September 1999.

By year, the number of HIV positive infected has increased from less than 100 before 1995, to 124 in 1997, 129 in 1998 and 138 during January and September 1999. The increasing pattern in the number of HIV positive infected is attributed to the increase in cases of voluntary examination for HIV including anonymous examinations caused by the increase in interest of personal health, which plays a role in detecting HIV infection. This can also be due to the continued awareness activities and education on voluntary examinations.

Table 3-11. Sex and Age Pattern of the HIV Infected in September 1999

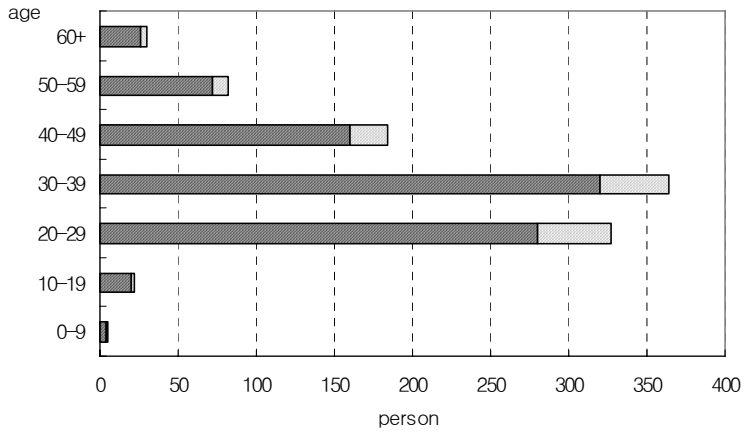
(Unit: person)

Age Group	Total	Male	Female
Total	1,014(224)	882(200)	132(24)
0～ 9	5(2)	4(2)	1(-)
10～19	22(1)	20(1)	2(-)
20～29	327(33)	280(30)	47(3)
30～39	364(88)	320(77)	44(11)
40～49	184(59)	160(52)	24(7)
50～59	82(27)	72(25)	10(2)
60+	30(14)	26(13)	4(1)

Note: 1) The age of the infected when detected.
2) ( ) is the number of deaths.
Source: National Institute for Health, *News report data,* September 1999.

The latest statistics show that 843 of the total 1,014 HIV positive patients were exposed to the epidemic through sexual intercourse(222 of them through homosexuality) and 21 of them through blood transfusion. By age bracket, 68.1 percent of the total 1,014 HIV positive patients are in the 20-30 year age bracket(Table 3-9).

Figure 3-3. Age and Sex Pattern of HIV Infected People in Sept. 1999 in Korea



It has been brought to attention that a large portion of those HIV/AIDS patients are of the "high-risk group" that are in need of RH services; that is, young people who are sexually active and yet hard to reach since they are highly mobile. Special programs need to be developed to reach those in the 20～30 age category who are most likely to contract sexually transmitted diseases(STDs) and HIV/AIDS.

As can be seen from Table 3-10, sexual intercourse is the most pronounced route of HIV infection, which accounts for 88.1 percent of HIV infected persons after excluding those under examination. Among those infected by sexual intercourse, homo-sexuality accounted for 26.3 percent. 367 persons were infected by heterosexual intercourse in Korea; this implies that HIV transmission is no longer a problem for foreign countries only but has become an internal problem. The number of infections by blood transmission is 21; 10 were transmitted within the country.

Table 3-12. HIV-Infected Persons by Route of Infection Transmission (1985~1999)

(Unit: persons)

Total	Sexual intercourse				Blood transfusion		Others	Under examination
	Sub total	Abroad	Domestic	Homo-sexual	Abroad	Domestic		
1,014	843	254	367	222	10	11	19	57

Source: National Institute for Health, *News report data,* September 1999.

3) STD/HIV/AIDS Prevention and Limitations

Sexually transmitted disease infection affects not only infected persons themselves but also their family, specifically their children, and causes socio-economic problems and losses. Sexually transmitted diseases increase the possibility of infection of HIV which is a pathogen of AIDS, resulting in the destroying of reproductive health and quality of life. Therefore, the goals of sexually transmitted disease prevention and control are to minimize not only its transmission, but also to maintain population quality.

A policy for management of AIDS was adopted for the first time in 1985, and in 1987 an AIDS Prevention Committee was established and AIDS was designated as a second class communicable disease by the Infectious Disease Prevention Act. In the same year, the AIDS Management Center was established within the National Institute of Health to carry out research, inspection, training, etc., and the AIDS Prevention Act, a law separate from the Infectious Diseases Prevention Act, was promulgated, pertaining to the duties of the government, local self-governing regions and people for the prevention of AIDS, prohibition of discriminatory treatment of AIDS patients, protection of patient confidentiality, report of HIV infection, evaluation of vulnerable groups, etc..

In strengthening the information and service delivery system through public health centers, health providers, including

family-planning providers, have therefore been provided training in counselling on sexually transmitted diseases and HIV infection.

AIDS related non-governmental organizations that have been established since 1993 include the Korean Anti-AIDS Federation (KAAF), Korean Federation for AIDS Affairs, Korean Alliance to Defeat AIDS, the Institute for the Movement to Stop AIDS, and Counseling for AIDS. The main role of those non-governmental organizations, including the Planned Parenthood Federation of Korea, is to reduce the spread of HIV infection through information, education and communication campaigns, which aim to raise awareness and emphasize behavioral change. Thus, non-governmental organizations provide counseling, publicity and education for the AIDS infected and public and education for medical personnel.

AIDS surveillance has been carried out through the regular examination of vulnerable groups in public health centers, examination of donated blood, voluntary anonymous free examinations, etc,. However, the persons that are examined are confined only to those who have access to public centers and hence the surveillance system has not played a full role in estimating the HIV infection rate. Regular examinations for AIDS have been expanded from workers employed in pink collar jobs to population groups vulnerable to STDs and sanitation sector workers, with the number of examinations reaching 33.3 million at the end of 1997.

In August 1999, the National Institute for Health(NIH) established a surveillance system, centered on 29 public health centers of which the jurisdiction included prostitution areas for the tight management and surveillance of STD/HIV. There are plans to expand the HIV surveillance system to all hospitals and clinics.

Public health centers provide counseling and health education on a regular basis for the infected and health examinations are provided by the National Institute for Health. The government provides drugs to the infected with weakened immunity and those

who have become immune to AZT injections(Azidothymidine). The government also reimburses expenses paid by AIDS infected and patients during treatment.

Two centers were established in Seoul in April 1998 to provide information and counseling services for the infected and their families; the total number of HIV infected who used these centers reached 605 by the end of September 1999. In addition, the AIDS Information Center was operated during January and September 1999, with the number of users being 3,324 for visiting and counseling, 12,731 for house-calls which was established in May 1999, and 1,600 thousand cases through computer communication.

The number of sexually transmitted disease infected, HIV infected and AIDS patients, though, has been increasing in Korea. Increase in sexually transmitted diseases and HIV infection may have increased because of changed attitudes towards sexual behaviour, tolerance towards sexual promiscuity, lack of knowledge and an inefficient control program. Unlike other communicable diseases, sexually transmitted diseases are hard to control due to their unique characteristics; difficulty in detecting the infection source, numerous re-infections resulting from lack of immunity from previous infection, and absence of therapeutic drugs available for AIDS. Traditionally, mentioning sexual activities has been a strong social taboo in Korea and hence, awareness activities and education on STD and AIDS has not yet been effective; social attitude towards the STD and AIDS infected has resulted in them being shunned so that the infected tend to be reluctant to receive counselling and treatment, and as yet there is no treatment for AIDS which causes the infected to feel despair and to be less careful of transmission of AIDS to others.

F. Future Policy Directions

Since the ICPD, the Korean government began efforts in the

right direction when it adopted a new population policy in 1996 which focuses on reproductive health programs, including family planning and maternal child health, STD and HIV and AIDS, and adolescent reproductive health. However, an integrated and comprehensive reproductive health scheme has not yet been fully developed, and its importance is not well recognized by policy makers and program managers. The following policy directions should be sought for successful implementation of reproductive health programs in Korea as established in the ICPD Programme of Action.

First, to ensure the success of the integrated reproductive health approach, pertinent program agencies involving reproductive health should be organizationally and functionally integrated. Integration efforts should be directed toward: 1) unifying the entire program-network, 2) developing a manual on integrated reproductive health services for use by health personnel at health centers, 3) developing a scheme for manpower supply to support integration, and 4) establishing a unique program management system with an integration approach. It is urgent that an innovative scheme be developed for program management which is easily adoptable to integration of the elements of reproductive health.

Second, a high level coordinating body consisting of representatives from concerned organizations involved in reproductive health programs should be established. Since reproductive health programs require multi-sector approaches involving various ministries, departments, institutes and non-governmental organizations, effective coordination among organizations will help to ensure smooth program implementation and avoid any duplication of efforts.

Third, the government should increase the program budget for additional reproductive health services. Central and local governments should share budgets for reproductive health programs, and expand their financial support for private organizations and non-governmental organizations, so that major

programs, particularly for adolescents and disadvantaged groups can be strengthened. However, at present, the self-financing capacity of local governments is relatively low, which means the central government should continue to provide financial support for local governments and non-governmental organizations.

Fourth, reproductive health should be included as a priority in National Health Promotion programs. Following the National Health Promotion Act enacted in 1995, the government has implemented health promotion demonstration programs at 18 health centers since 1997. The demonstration program will be spread nationwide after appraisal of its practicability and appropriateness.

Fifth, as emphasized by the ICPD Programme of Action, prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and contraceptive services should be offered promptly, which will also help to avoid repeat abortions.

Finally, a unified information system for reproductive health programs should be developed through close coordination between health centers and related private organizations. Comprehensive indicators for monitoring of reproductive health programs should also be developed for use at central and local levels.

In order to be able to overcome the various problems associated with reproductive health, as well as the major challenges stemming from the below replacement fertility in Korea, the importance of current family planning should not be underestimated, simply because demographic targets have been met. In addition, research studies on reproductive health should also be continuously conduced, and further efforts should be put towards making policy makers and program managers understand the importance of reproductive health for its success.

Chapter 4. Health, Morbidity and Mortality

A. Health Development

The ICPD Programme of Actions urges all countries to reduce mortality and morbidity and to seek to make primary health care, including reproductive health care, universally available by the end of this decade[6]. Efforts to ensure a longer and healthier life for all should emphasize the reduction of morbidity and mortality differentials between males and females, as well as among geographical regions, social classes and indigenous and ethnic groups. The government should seek to make basic health-care services more financially sustainable, while ensuring equitable access, by integrating reproductive health services, including maternal and child health and family-planning services, and by making appropriate use of community-based services, social marketing and cost-recovery schemes, with a view to increasing the range and quality of services available.

In Korea, it was not possible to put health into full consideration in the First Five-Year Economic Development Plan from 1962 to 1966, due mainly to lack of finances. Accordingly, the level of health did not improve much during the First Plan; there was not much improvement in the prevention of infectious diseases, expansion of health facilities, networking of nationwide health and medical organizations, etc. However, inclusion of Family Planning into the First Development Plan, which was

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6) Countries should aim to achieve a greater than 70 year life expectancy at birth by 2005 and a greater than 75 year life expectancy at birth by 2015. Countries with the highest levels of mortality should aim to achieve a greater than 65 year life expectancy at birth by 2005 and a life expectancy greater than 70 years at birth by the year 2015.

aimed at suppressing the high population growth rate to facilitate economic development, played a role in reducing the maternal and infant mortality rates to some extent.

Health was included as an important component in the Second Five-Year Economic Development Plan(1967～1971). It included disease prevention and monitoring, improved integration of maternal and child health with family planning, expansion of health and medical networks, etc. Emphasis in prevention of diseases was put on tuberculosis, leprosy, typhus fever, diphtheria, encephalitis, and parasitic diseases. Further efforts were made to reinforce education and awareness to increase public awareness and induce active participation in preventing those diseases. Also, health facilities were expanded to improve the health environment. Specifically, maternal and child health played an important role in declining the population growth rate through improved pre- and post-natal care and health of infants. The health plan was implemented, centered on rural areas, and includes expansion of the health network and emphasis on health education.

In the previous two development plans, health was dealt with less importantly than economic development. Accordingly, health was included as a primary component to accelerate economic development and improve the level of health and welfare for the people in the Third Five-Year Economic Development Plan(1971～1976). Thus, the Plan took into consideration population structure, population distribution, level of economic development, change in consumption pattern, change in employment structure, etc. as important factors affecting the level of people's health. Increase in population size raised the demand for health and medical services and transformation in diseases with change in the age structure necessitated the importance of the health industry.

The reduction in the fertility rate resulted in need to increase maternal and child health and school health, the increase in the urban population required expansion of health infrastructure, such as pollution prevention facilities, sanitation facilities and water

supply and drainage, etc., and the population ageing in rural areas increased the necessity of dealing with degenerative chronic diseases. Thus, the health part in the Development Plan was aimed at improving people's health, accommodating a sanitary environment, expanding the health infrastructure including health and medical personnel and facilities, together with health related finances. The targets included reduction in the crude death rate, infant mortality rate, morbidity rate, increase in life expectancy, improvement in the people's nutritional status, increase in the coverage rate of health insurance, increase in health and medical personnel, etc.

With the income increase resulting from the success of the previous economic development plan, the number of people per medical doctor decreased from 2,609 in 1965 to 2,100 in 1975, and the number of people per bed decreased from 2,481 to 1,764, respectively. The infant mortality rate decreased from 50 per 1,000 live births in 1965 to 38 in 1975 and the T.B. morbidity rate from 5.1 percent to 3.3 percent, respectively. However, the rapid increase in medical prices and concentration of health and medical infrastructure into urban areas created an imbalance in medical and health services and, hence, health status between urban and rural areas.

In the mean time, pollution became serious along with industrialization, specifically in urban areas. Therefore, the Fourth Five-Year Economic Development Plan put emphasis on the provision of health and medical services at lower prices and balance between urban and rural areas, increase in supply of health and medical personnel, disease prevention, and improvement in sanitary environment.

To supply cheap health and medical services, the Government planned to increase the number of public health centers including branches with sufficient equipment to primary health organizations, to 308, during the plan period. For secondary health organizations, municipal and provincial public hospitals were to be expanded with

supply of personnel and facilities. The maternal mortality rate was to be reduced from 56 per 100,000 mothers in 1975 to 30 in 1981 and the infant mortality rate from 38 per 1,000 live births to 20.

The prevention of acute communicable diseases was reinforced through early detection and treatment of diseases and supply of free-food provided for the schooling population. In order to expand the health and medical personnel, a long-term plan for supply of health and medical personnel was established; medical, nursing and pharmacy colleges were to be the focus of education for professional medical personnel, specifically at the provincial level. The expansion of the water supply and drainage was to be emphasized not only in large cities, but also in medium and small cities. Technology was to be studied and developed for pollution prevention.

With increase in income, the price for health and medical services also increased. This deteriorated the balance in health and medical services between urban and rural areas and between socio-economic classes. To respond to the spread of inequality in the demand for medical and health services between various classes, the government needed to strengthen the development of an effective health and medical service delivery system at low prices. Thus, in the Fifth Five-Year Socio-economic Development Plan(1982～1986), the Government planned to establish small, medium and large networks of health and medical services.

The contract-basis employment of medical personnel was to be ensured to induce cheaper services. The expanded number of medical doctors in military service duty was to be allocated to rural areas. The number of beds and the number of new medical personnel were to be increased, specifically in rural areas.

The function of public health centers was to be strengthened with increase in number in rural areas and for low income classes in urban areas; this included the expansion of public health personnel in small communities and encouragement of active participation by the community, expansion of medical

facilities in rural areas, and operation of mobile medical services for rural areas and low income classes in urban areas. The safety of food, medical and pharmaceutical products was also to be guaranteed. The treatment and management of mental diseases was also to be reinforced through networking of the national psychopathic hospital, municipal and province hospitals and public health centers, promulgation of the Psychopathic Health Law, increase in the number of beds for psychopathic patients, and implementation of registration of patients. The water supply and drainage system were also to be expanded and improved.

Along with economic development and increase in people's interest in health, the government's active health policy also played a role in improving the status of the people's health. However, the improvement in living standards resulted in a growing demand for further diverse health and medical services, specifically affordability and accessibility.

Moreover, an inequality in health and medical services existed between social classes; although 56.9 percent of the total population was covered by health insurance or medical aid, the remaining proportion, concentrated in the rural or poor population, was not covered and paid expensive medical prices. In addition, rapid industrialization, which is often related to increase in pollution and accidents, increased the demand for health and medical services. For example, the number of traffic accidents increased by 51 percent between 1980 and 1985 and the number of industrial injuries by 41 percent. Specifically, the ageing of the population resulted in change in diseases from acute communicable diseases to non-communicable chronic diseases, which raised the cost of health care.

Accordingly, the Sixth Five-Year Socio-economic Development Plan(1987～1991), aimed to expand coverage of health insurance, establish the health care system, expand health and medical facilities in rural areas, and modernize the public health and sanitary system.

In order to expand coverage of health insurance, the entire population was covered by expanding coverage to the rural population in 1988 and urban population in 1989. Specifically, the contributions for the lower class were to be subsidized by the government. The health care system was established to increase accessibility to health care services. In order to achieve balance in services, to meet the growing demands between rural and urban areas, the government induced establishment of new hospitals and other facilities in rural areas, and restricted the concentration of health and medical facilities into urban areas. Specifically, the function of public health centers was to be strengthened to become primary health organizations in rural areas.

In the 1990s, the most pronounced change was the accelerated ageing of the population with increase in life expectancy, which resulted in change of the disease pattern to non-communicable degenerative chronic diseases. Such change in diseases, particularly of the elderly, increased the demands for health care and medical costs. Another serious issue is family nuclearization, specifically the increase in single parent households, and the effect of increase in women's economic participation rate on elderly care at home, since the elderly suffering from chronic diseases require more and longer care.

With the growing interest in health, individuals require more and higher quality health and medical services at cheaper prices from the government. Thus, the Seventh Five-Year Socio-economic Development Plan(1992～1996) aimed to prevent diseases and strengthen health education, stabilize the health security system, ensure affordability and equality of the health service supply, improve food safety, water and commodities, develop the health industry, secure medical and pharmaceutical products, and secure the appropriateness of health costs and protection of consumers.

Thus, the rise in income resulting from economic development in Korea has expedited improvement of the health status of the population. In efforts to further improve the health

of the people by meeting the growing demand for health services, the government has increased high quality medical personnel and health care facilities to increase access to health care services for all people and especially for the most underserved and vulnerable groups. The health service and other systems have been developed to distribute health support personnel and health resources.

The number of medical facilities, as a whole, increased from 14,386 in 1982 to 38,038 in 1998, or by 2.6 times during a 16 year period. More specifically, the number of general hospitals increased by 2.3 times and the number of clinics by 2.5 times, during the same period. The number of beds per 100,000 persons also increased two times, from 231 in 1984 to 517 in 1998. Along with the expansion of medical facilities and personnel, the government has also strengthened the provision of publicity and education on health through various channels, such as mass-media. Above all, rise in income has increased people's interest in health.

Table 4-1. Trends in Medical Facilities, 1982~1998

	Total Medical Facilities[1)]	General Hospitals	Hospitals	Clinics	Beds per 100,000 persons
1982	14,386	111	263	6,824	231[2)]
1985	18,322	183	317	8,069	245
1990	25,317	228	328	10,935	313
1995	33,377	266	398	14,343	435
1997	36,294	262	456	15,876	456
1998	38,038	255	517	17,041	517

Note: 1) Including specialized hospitals.
2) for 1984.
Source: Ministry of Health and Welfare, *Yearbook of Health and Welfare Statistics*, each year.

The increase in medical facilities and medical personnel has resulted in the number of persons per medical doctor

decreasing from 3,221 in 1960 to 710 in 1998, or by 78 percent during this period(see Table 4-1). Persons per dentist also decreased from 18,270 in 1960 to 2,879 in 1998(Table 4-2). However, these rates are still high, compared to 385 for medical doctors and 1,667 for dentists, respectively, in the USA.

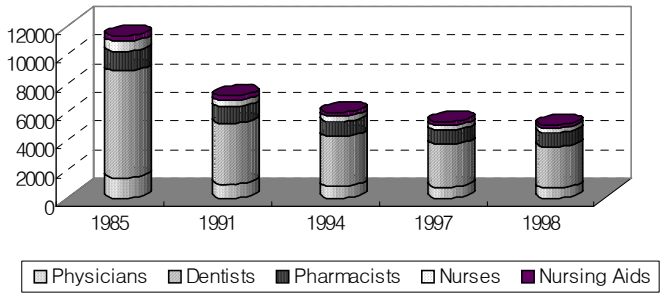
Table 4-2. Persons per Medical Personnel, 1960~1998

	Physicians	Dentists	Pharmacists	Nurses	Nursing Aids
1960	3,221	18,270	-	-	-
1970	2,159	15,194	-	-	-
1980	1,690	10,531	-	-	-
1985	1,379	7,507	1,366	690	384
1991	952	4,271	1,128	454	301
1994	821	3,450	1,062	390	252
1997	735	2,990	1,004	343	222
1998	710	2,879	988	329	212

Source: Korea Institute for Health and Social Affairs, *1998 Health and Welfare Indicators in Korea,* 1998.

There has been considerable progress in the medical system in Korea. The three major institutional and legal supports for improved RH services come from the National Health Insurance program, the National Health Promotion program, and the New Population Policy.

Figure 4-1. Trends in Persons per Medical Personnel in Korea



The medical insurance program, which is aimed at making basic health care services more financially sustainable, is based on the Medical Insurance Act of 1963 which was revised in 1976. Under the revised law, medical insurance for large-scale industries with 500 or more employees became obligatory. In 1979 another revision to the existing insurance program went into effect: that is, the insurance scheme also became obligatory in medium-sized industries with 300 or more employees. In yet another revision in 1988, medical insurance coverage was expanded to work places with more than five employees and to rural residents. Finally in 1989, the government succeeded in introducing compulsory medical insurance for the entire population. In 1999, medical insurance was changed, in name, to health insurance, and it became prevention-oriented, rather than treatment-oriented as in the past.

The National Health Promotion Act was enacted in January, 1995 to enhance, among individual citizens, the quality of their lives through a variety of "healthy life" demonstration programs at public health centers throughout the country. Through this Act, the government endeavors to create a social environment in which smoking in non-smoking areas and disorderly drinking will not be allowed. Also included in the program is the constructing of a national health education database. The Ministry of Health and Welfare is currently implementing a three-year demonstration project(from 1999 to 2001) for the improvement of basic health, including reproductive health, at the community level, centered on 23 public health centers out of 243 centers.

The ICPD Programme of Action recommends that governments ensure community participation in health policy planning, especially with respect to long-term care of the elderly, those with disabilities and those infected with HIV and other endemic diseases; such participation should also be promoted in programs for child and maternal health, breast-feeding support, early detection and treatment of cancer of the reproductive system, and prevention of HIV infection and other sexually transmitted diseases.

The Regional Health Law, enacted in 1996, aims to promote a community where health promotion for local people can be planned, implemented, monitored and evaluated, based on local health characteristics and need to secure finances.

B. Reduction in Mortality

With increase in the accessibility, availability, acceptability and affordability of health-care services and facilities that are concomitant with socio-economic development, there has been a drastic decline in mortality in Korea. Specifically, Korea experienced a rapid decrease in the levels of infant and maternal mortality. In the meantime, the structure of cause of death in Korea has changed from communicable acute disease predominance to non-communicable chronic disease predominance, which is attributable to the change in life style with rise in income and health system development. This sub-section discusses the change in the level of infant and maternal mortality rates and in the structure of cause of death and their contributing factors.

1) Infant and Maternal Mortality Rates

The ICPD Programme of Action recommends that countries strive to effect significant reductions in maternal mortality by the year 2015: a reduction in maternal mortality by one half the current level in 1990 by the year 2000 and a further half by 2015. In doing so, the ICPD Programme of Action recommends that for programs to be able to reduce maternal morbidity and mortality they should include information and reproductive health services, including family-planning services; in order to reduce high-risk pregnancies, maternal health and safe motherhood counselling and family-planning information should be included.

Table 4-3. Trends in Infant Mortality Rate(IMR) and Maternal Mortality Rate(MMR), 1960~1996

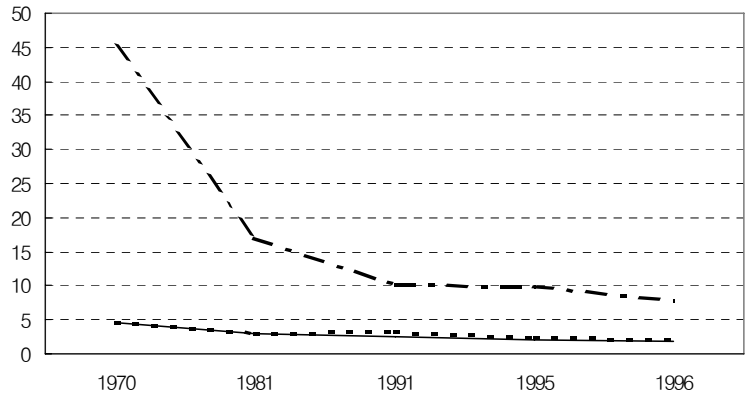
	1960	1970	1981[2]	1985	1991	1995	1996[3]
Infant Mortality Rate	83	45	17	13	10.0[3]	9.94)	7.7[4]
Child Mortality Rate							
Male	-	4.7	2.9	-	3.2	2.2	2.0
Female[1]	-	4.5	2.9	-	2.6	2.0	1.8
Maternal Mortality Rate	-	-	-	-	-	20	20

Note: 1) Child mortality rate(CMR) is for children under 5 years of age.
2) Child mortality rate is for 1980.
3) Child mortality rate is for 1997.
4) '-' is 'not available'.

Source: Korea Institute for Health and Social Affairs, *1998 Health and Welfare Indicators in Korea*, 1998.
National Statistical Office, *Social Indicators*, 1992.
Han, Youngja, et al. *Level and Causes of Infant Mortality Rate and Perinatal Death Rate for 1996*, Korea Institute for Health and Social Affairs and Ministry of Health and Welfare, 1998.

Under the current maternal and child health program in Korea, expectant mothers are able to receive diverse pre-natal care at maternity hospitals and, if need be, newborn babies may be subject to congenital metabolic disorder tests, including the congenital thyroid malfunction test. Intensive family planning has played a role in decreasing the total fertility rate from 4.5 in 1970 to 1.48 in 1998, mainly through increased contraception rate. Thus, the maternal and child health program and family planning, together with improvement in nutrition and advancement in medical technology, have contributed to the decrease in infant mortality rate and maternal mortality rate; the infant mortality rate decreased from 45 per 1,000 live births in 1970 to 7.7 in 1996 and the maternal mortality rate decreased to 20 in 1996(see Table 4-3).

Figure 4-2. Changes in Infant Mortality Rate and Child Mortality Rate in Korea



2) Changes in Structure of Cause of Death

All these efforts, together with socio-economic change, have played a crucial role in increasing life expectancy at birth; the life expectancy at birth increased from 52.4 years for both sexes in 1960 to 73.4 years in 1997(Table 4-4), mainly through increased accessibility to appropriate health services for prevention and treatment of diseases.

Table 4-4. Trends in Life Expectancy, 1960~1997

(Unit: years)

	1960	1970	1977	1985	1991	1993	1995	1997
Both sexes	52.4	63.2	64.5	68.4	71.7	72.8	73.5	73.4
Male	51.1	59.8	60.8	64.5	67.7	68.8	69.6	70.6
Female	53.7	66.7	68.7	72.8	75.9	76.8	78.4	77.1
Difference	2.6	5.9	8.0	8.3	8.2	8.0	7.8	7.6

Source: National Statistical Office, 1971~1997 *Life Tables for Korea.*
National Statistical Office, *Future Population Projection,* 1996.

Regarding the causes of death in Korea, shown in Table 4-5, cerebrovascular diseases are the most predominant, followed by traffic accidents, liver diseases, malignant neoplasm of the stomach, malignant neoplasm of the liver, diabetes mellitus, etc.

During the past ten years from 1988 to 1997, the death rate by diabetes mellitus has had the most considerable increase, with increase rate of 154.1 percent. The following causes of death, which have increased during the past ten years, include malignant neoplasm of the trachea, bronchus and lung(76.3 percent), suicide(65.9 percent), traffic accidents(42.6 percent), etc,. The death rates by hypertensive diseases(-75.9 percent), T.B.(-47.0 percent), pneumonia(-42.4 percent), malignant neoplasm of the stomach(-18.7 percent), liver diseases(-22.1 percent), malignant neoplasm of liver(-5.4 percent), etc,. have decreased during the same period though. No improvement has been seen in the rate of death from cerebrovascular diseases.

Table 4-5. Trends in Death Rates by Major Cause of Death, 1988 and 1997

(Unit: per 100,000 persons)

Cause of death	1988			1997			1988～1997 (percent)		
	total	male	female	total	male	female	total	male	female
All	546.4	630.4	461.0	518.3	579.9	456.1	-5.1	-8.0	-1.1
T.B.	13.4	19.4	7.2	7.1	10.5	3.7	-47.0	-45.9	-48.6
Stomach cancer	31.5	38.8	25.9	25.6	32.4	18.8	-18.7	-16.5	-21.3
Liver cancer	22.4	33.4	10.9	21.2	32.3	10.0	-5.4	-3.3	-8.3
Lung cancer	11.8	17.1	6.2	20.8	30.5	10.9	76.3	78.4	78.5
Diabetes	7.4	8.0	6.8	18.8	19.2	18.5	154.1	140.0	172.1
Hypertension	39.9	43.4	36.3	9.6	8.5	10.8	-75.9	-80.4	-70.2
Cerebrovascular	73.3	74.9	72.2	73.5	70.9	76.1	0.3	-5.3	5.4
Pneumonia	8.5	9.3	7.8	4.9	5.7	4.1	-42.4	-38.7	-47.4
Liver disease	33.5	52.6	13.4	26.1	41.9	10.2	-22.1	-20.3	-23.9
Traffic accident	23.5	34.7	11.7	33.5	49.2	17.5	42.6	41.8	49.6
Suicide	8.5	11.9	4.9	14.1	19.5	8.7	65.9	63.9	77.6

Note: Death rate by suicide is per 100,000 persons 5 years of age or over.
Source: National Statistical Office, *1997 Report on Cause of Death*, 1998.

Among causes of death, the decrease in death rate by T.B. can be attributed to the success of the tuberculosis control program, together with improvement in nutrition, thanks to the rise in income. The decrease in death rate due to hypertensive disease, liver disease, malignant neoplasm of the liver and stomach may be attributed to the change in dietary habits, including drinking and regular examinations, which expedite early detection and treatment of diseases. However, the death rates from liver disease, malignant neoplasm of the liver, stomach, and lung, traffic accidents and suicide, most of which are a result of social stress, drinking and smoking behavior and accidents, are still high in comparison to OECD member countries.

C. New Challenges

While the number of diagnoses per 1,000 persons increased from 80.9 in 1989 to 98.5 in 1995, the rate of bed utilization decreased from 78.8 percent in 1989 to 65.5 percent in 1995. This may be attributed to the increase in demand for health care since the introduction of the health insurance scheme in 1989 and expansion of medical facilities.

Nonetheless, the morbidity rate increased from 16.6 percent in 1989 to 19.0 percent in 1995, implying that modern life style causes accidents and stress, which often results in drinking and smoking and subsequently in chronic diseases, and that rapid population ageing has resulted in predominance of elderly people suffering from noncommunicable chronic diseases. In other words, the number of people with unhealthy conditions has increased along with the increase in life expectancy at birth.

According to health expectancy numbers derived from the National Health Interview Survey(KIHASA, 1995), which is presented in Table 4-6, the health expectancy for females and for males was 47.07 years and 48.50 years, which is shorter than the

life expectancy of 30.3 years and 21.0 years, respectively. The comparison between males and females indicates that although females outlive males, males live longer than females in health. Therefore, special programs should be developed to monitor the morbidity of females.

Table 4-6. Life Expectancy and Health Expectancy, 1995

(Unit: years)

	Life expectancy(A)	Health expectancy(B)	Difference (A-B)
Male(C)	69.57	48.50	21.07
Female(D)	77.41	47.07	30.37
Difference (C-D)	-7.84	1.43	-

Source: Korea Institute for Health and Social Affairs, *National Health Interview Survey*, 1995.
National Statistical Office, *1971~1997 Life Tables for Korea*, 1999.

The recent economic recession has had a direct impact on people's health. The number of undernourished children has increased and according to the Ministry of Education, as of late 1998 there were over 130 thousand children missing meals in all elementary and middle schools, which is 13 times the amount in the beginning of that year. There has also been a rapid increase in addiction to alcohol, drugs, etc,. According to results of the joint survey conducted by the Korea Institute for Health and Social Affairs(KIHASA) and Korea Labor Institute(KLI), 23.8 percent of the unemployed stopped receiving health care or treatment because of expensive medical treatment costs. 1.4 percent of the unemployed had experienced mental illness.

The crisis has affected the affordability and quality of basic social services. As a result there are signs of rising levels of health deprivation, declining school enrollment and more drop-outs. These trends appear to have affected women and children the most. The crisis has also exacerbated the existing

difficulty of access to reproductive health services, especially for adolescents and youth, many of whom are now part of the newly formed poor.

In addition, increase in access to health services has resulted in rising health expenditures, which puts a great burden on the national health insurance scheme, namely through lack of finances.

D. Future Policy Directions

Special programs should be designed to further reduce the mortality and morbidity rates from malignant neoplasms; these include strengthening of the movement to change dietary habits, refrain from smoking and drinking, increase exercise, etc,. Specifically, early detection and treatment of cancers, including malignant neoplasms of the breast, uterus, stomach, etc. should be strengthened in primary health at the community level. Education and awareness activities relating to these should be provided on a continuous basis.

A comprehensive mid-term plan for health promotion should be established for implementation of the National Health Promotion program. The current Five-Year Plan for health and medical development is aimed mainly at improving the support-system for health promotion. Therefore, it should be linked more concretely to national health promotion. The government should increase support and assistance, financially and technically, to attain the goals for health improvement at the community level. Every decision on health, both at the national and community levels, should involve all parties.

For legal support, all existing laws, including the National Health Promotion Act, Regional Health Law, School Health Law, etc., should be further developed or reformed to include what is necessary for actual implementation and avoidance of duplication.

Health policy by life cycle, which is being implemented,

should be reinforced to cover all classes, and planned and implemented according to characteristics of the people, by life cycle. School health programs should be integrated into regional health programs, specifically to improve the reproductive health of adolescents. This should enable public health centers at the community level to cover adolescents as a target population in its programs and provide access to public health.

In Korea, the maternal mortality rate is relatively still high. As suggested by the ICPD Programme of Action, the provision of maternal health services in primary health care should include education on safe motherhood, focused and effective prenatal care, maternal nutrition programs, adequate delivery assistance that avoids the excessive recourse of caesarean sections and provides for obstetric emergencies; referral services for pregnancy, childbirth and abortion complications; post-natal care and family planning. The underlying causes of maternal morbidity and mortality should be identified, and attention should be given to the development of strategies to overcome them and for adequate evaluation and monitoring mechanisms to assess the progress being made in reducing maternal mortality and morbidity and to enhance the effectiveness of ongoing programs.

Sufficient resources should be assigned so that primary health services attain full coverage of the population. The government should strengthen health and nutrition information, education and communication activities so as to enable people to increase their control over and improve their health.

Chapter 5. Gender Equality, Equity and Empowerment of Women

A. Status of Women and Need for Further Empowerment of Women

The ICPD Programme of Action urges countries to act to empower women and take steps to eliminate inequalities between men and women by establishing mechanisms for women's equal participation and equitable representation at all levels of the political process and public life in each community and society and by enabling women to articulate their concerns and needs; to promote the fulfillment of women's potential through education, skill development and employment, giving paramount importance to the elimination of poverty, illiteracy and ill health among women; eliminate all practices that discriminate against women; assist women to establish and realize their rights, including those that relate to reproductive and sexual health; adopt appropriate measures to improve women's ability to earn income beyond traditional occupations, achieve economic self-reliance, and ensure women's equal access to the labour market and social security systems; eliminate violence against women; eliminate discriminatory practices by employers against women, such as those based on proof of contraceptive use or pregnancy status; and make it possible, through laws, regulations and other appropriate measures, for women to combine the roles of child-bearing, breast-feeding and child-rearing with participation in the work-force.

The ICPD Programme of Action also urges that all countries make greater efforts to promulgate, implement and enforce national laws and international conventions to which they are party, such as the Convention on the Elimination of All Forms of Discrimination

against Women, that protect women from all types of economic discrimination and sexual harassment, and to implement fully the Declaration of the Elimination of Violence against Women and the Vienna Declaration and Programme of Action adopted at the World Conference on Human Rights in 1993.

1) Economic Activity

The ICPD Programme of Action urges governments and employers to eliminate gender discrimination in hiring, wages, benefits, training and job security, for the elimination of gender-based disparities in income. It is also recommended that the government ensure that policies and practices comply with the principle of equitable representation of both sexes, especially at the managerial and policy-making levels, in all programs, including population and development programs.

In Korea, though the participation of women in the labor force gradually increased from 40.5 percent in 1981 to 59.8 percent in 1998 for married women, the labor force participation rate remained at 46 percent for unmarried females(refer to Table 5-1). The sharp increase in the economic participation rate of married women between 1996 and 1998 implies that the recent economic crisis has forced married women to be employed in part-time work with low income and bad working conditions.

Table 5-1. Economic Participation Rate of Females, by Marital Status, 1981~1998

(Unit: %)

	1981	1985	1990	1996	1998
Total females	42.3	41.9	47.0	48.7	47.0
Unmarried	47.7	39.5	45.6	46.0	46.0
Married	40.5	41.9	46.8	50.5	59.8

Source: National Statistical Office, *Report on Economically Active Population,* 1981~1998.

Women have traditionally been responsible for household work and child-care. The traditional gender roles for males and females are changing with the increase in women's participation in economic activities, though. However, the relatively small participation of husbands to housework and child-care is and has remained relatively small to wives', which is often not related to whether the wife has a paid job or not. The stress and overwork of mothers that work outside often results in family conflicts and sometimes family dissolution.

Table 5-2. Number of Female Professionals and Technicians, and Legislators, Senior Officials and Managers, 1993~1998

(Unit: thousand persons, %)

	Total Female Employed	Professionals, Technicians & Associates		Legislators, Senior Officials and Managers	
		Number	Percent	Number	Percent
1993	7,774	824	10.6	32	0.43
1994	8,043	814	10.1	25	0.31
1995	8,256	899	10.9	23	0.28
1996	8,472	970	11.4	25	0.30
1997	8,686	1,013	11.7	25	0.29
1998	8,084	1,026	12.7	27	0.33

Source: Nation Statistical Office, *Report on Economically Active Population*, 1998.

As can be seen from Table 5-2, there has been a slight increase in the proportion of females working as professionals and technicians, at 12.7 percent of total female workers in 1998, compared to 10.6 percent for 1993. However, less improvement has been shown in the proportion of females working as legislators, senior officials and managers, with females accounting for 0.4 percent in 1993, but 0.3 percent in 1998. Only 11 females(3.68 percent) participated in the 15th National Assembly, and 2.3 percent in self-governing assemblies in 1998[7]. In 1997, women in clerical occupations accounted for 15.8 percent of the

whole female workforce, 25.6 percent were in production work and 33.7 percent in sales and services.

To ensure equal participation of women and men in the decision-making process of political affairs in national development, the Korean government has made efforts to increase the proportion of women in governmental committees, and plans to increase the proportion to 30 percent by 2002. A female public employee target system has been implemented to facilitate the recruitment of a target number of women into the public sector each year; the proportion of women employed in the public sector was 10 percent and was planned to reach 20 percent by 1999.

Among female workers, unpaid family workers accounted for 25.5 percent of female workers in 1995, which is a decrease from 60.5 percent in 1960, while paid employees accounted for 38.0 percent in 1997, an increase from 16.1 percent in 1960.

Although the economic participation of women and their status has improved, their work tends to be part-time, temporary and intermittent, and most working women are generally concentrated in low-wage industries and small companies. Furthermore, women still face sexual discrimination in the labor market, including gender wage gaps in favor of men, limited opportunities for work or discontinuity of work, and lack of job security, as can be seen in Table 5-3. Such inequality may come from less speciality or skill of female workers than men, and although the female workers work almost same time as the male workers do, they earn less income and are more exposed to job leave than male workers(refer to Table 5-3). Other gender discrimination may include disadvantages in recruitment, limited opportunities for promotion, lack of child care centers, and hazardous working conditions.

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7) The IPM announced that the female ratio in the National Assembly of ROK ranks 129th among 163 countries.

Table 5-3. Gender Comparison of Wages, Working Experience, Working Hours, and Job Leave Rate, 1975～1997

(Unit: %)

	Wages[1)]	Working experience[2)]	Working hours[3)]	Job leave rate[4)]
1975	42.2	53.3	-	-
1980	44.5	58.8	103.3	140.5
1990	55.0	53.2	100.5	138.9
1995	59.9	57.6	98.3	130.0
1996	61.5	61.7	97.2	136.7
1997	62.5	62.9	95.5	140.2
1998	63.7	-	97.6	139.7

Note: 1) Monthly salary for females/monthly salary for males×100.
2) Working years for females/working years for males×100
3) Working hours per week for females/average hours per week for males×100.
4) Job leave rate for females/job leave rate for males×100

Source: Ministry of Labor, *Report on Monthly Labor Survey*, each year.
Ministry of Labor, *Survey Report on Wage Structure*, each year.

2) Women's Development

A serious gap in school enrollment rates still remains between the sexes, with the female enrollment rates being lower in higher educational institutions. The average years of educational attainment in 1995 was 9.4 years for females and 11.2 years for males, a difference of 1.8 years between the sexes.

Comparison of the proportion of females aged 20～24 who have graduated from high school or higher of total females aged 20～24 with the proportion for males aged 20～24 is shown in Table 5-4. The female to male ratio was 53.8 percent in 1970, but increased considerably to 86.4 percent in 1985 and 101.4 percent in 1995. The female to male ratio for college graduation or higher for ages 25～29 was 38.9 percent in 1970, but

increased to 55.5 percent in 1985 and 85.5 percent in 1995. However, the educational discrimination against females still seems to be prevalent for education in college or higher in Korea.

Table 5-4 Proportion of Educational Attainment Among Age Groups 20~24 and 25~29 by Sex, 1970~1995

(Unit: %)

	1970	1975	1980	1985	1990	1995
Male(A)						
High school or over for ages of 20-24[1)]	42.2	34.1	58.3	77.2	89.5	94.5
College or over for ages of 25-29[2)]	10.8	10.5	13.2	18.2	28.1	35.2
Female(B)						
High school or over for ages of 20-24[1)]	22.7	29.8	43.9	66.7	86.4	95.8
College or over for ages of 25-29[2)]	4.2	5.8	7.7	10.1	19.2	30.1
Female/Male(B/A)						
High school or over for ages of 20-24	53.8	87.4	75.3	86.4	96.5	101.4
College or over for ages of 25-29	38.9	55.2	58.3	55.5	68.3	85.5

Note: 1) Proportion of males(or females) who have high school or higher educational attainment to total males(or females) aged 20~24.
2) Proportion of males(or females) who have high school or higher educational attainment to total males(or females) aged 25~29.

Source: Calculated by the National Statistical Office, *Population and Housing Census Report*, each year.

The distribution of majors at the university level shows that the majors preferred by females are humanities, teaching, linguistics, social science, and arts, while male students preferred social science, engineering, and natural sciences. Therefore, the government has put forward efforts to extend co-education, counselling on career guidance which is free of gender-bias, developing teaching materials without gender bias and increasing the female ratio of school principals(Chang, 1999).

International comparison of the status of Korean women with other countries for 1999 shows that the human development

index(HDI) was 0.852, which ranks 30th in the world; the gender-related development index(GDI) was 0.845, which was 30th among all countries; and the gender empowerment measure(GEM) was 0.336, which was 78th among all countries(see Table 5-5). These indices imply that Korean women's status is still low.

Table 5-5. International Comparison of Human Development Index(HDI), Gender-related Development Index(GDI), and Gender Empowerment Measure(GEM), 1999[8]

Order	HDI(score)		GDI(score)		GEM(score)	
1st	Canada	0.932	Canada	0.928	Norway	0.810
2nd	Norway	0.927	Norway	0.927	Sweden	0.777
3rd	USA	0.927	USA	0.926	Denmark	0.765
4th	Japan	0.924	Australia	0.921	Canada	0.742
5th	Belgium	0.923	Sweden	0.919	Germany	0.740
6th	Sweden	0.923	Belgium	0.918	Finland	0.737
7th	Australia	0.922	Iceland	0.918	Iceland	0.721
8th	Netherlands	0.921	Japan	0.917	USA	0.708
9th	Iceland	0.919	Netherlands	0.916	Australia	0.707
10th	UK	0.918	France	0.916	Netherlands	0.702
30th	Korea	0.852	Korea(30th)	0.845	Korea(78th)	0.336

Source: UNDP, *Human Development Report 1999*, 1999.

B. Sex Preference and Imbalance in Sex Ratio at Birth

One noteworthy feature of Korean society is that there are still women who resort to induced abortion, however small the proportion may be, to have a son rather than a daughter, through such sex pre-selection methods as amniocentesis. This may be one of the factors that has contributed to the unusually

8) In 1997, Korea was ranked 32nd for HDI, 35th for GDI, and 73rd for GEM.

high sex ratio at birth, in particular, of the third and higher order birth(Cho, et. al., 1994). The total fertility rate for 1995 hovered around 1.7 and since then virtually every couple has wanted to have at least more than one child, hence the sex ratio for first birth does not deviate much from the usual 105, but beginning with the second birth order, the ratio deviates greatly from the norm as more and more couples decide to abort, either because they "did not want the child", the fetus proved to be of the sex that they did not "favor," or both.

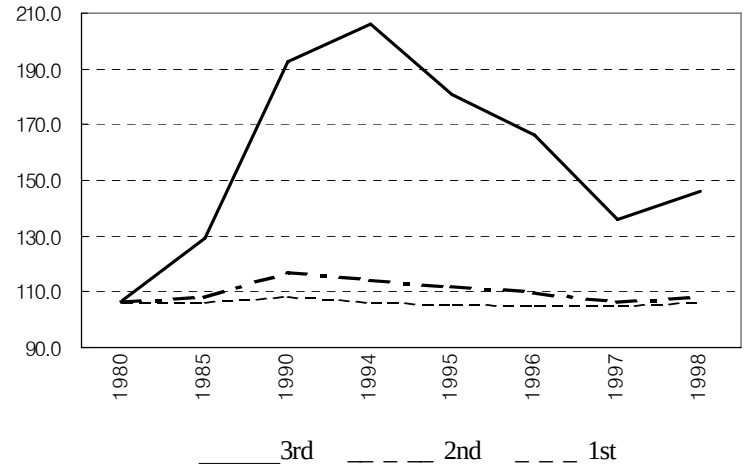
As evident from Table 5-6, the imbalance of the sex-ratio at birth is improving annually, from a peak of 115.3 in 1993 to 108.4 in 1997, but rather than being caused by alleviation of the male preference, this can be explained by the government's strict enforcement of the medical law; as an effort to prevent selective induced abortions from exacerbating the current sex imbalance, the government made a revision to the then existing medical law in October, 1996.

Table 5-6. Sex Ratio at Birth[1] by Birth Order, 1980~1998

Year	Total	Birth Order		
		1st	2nd	3rd or over
1980	105.3	106.0	106.5	106.9
1985	109.5	106.0	107.8	129.1
1990	116.5	108.5	117.0	192.8
1994	115.2	106.0	114.1	205.8
1995	113.2	105.8	111.7	180.6
1996	111.6	105.3	109.8	166.5
1997	108.3	105.1	106.3	135.8
1998	110.2	106.0	108.1	146.0

Note: 1) number of male live births per 100 female live births.
Source: National Statistical Office, *1998 Report on Vital Statistics*, 1999.

Figure 5-1. Trends In Sex Ratio at Birth by Birth Order in Korea



Under the revised law, those medical doctors who perform abortions for reasons of sex selection have their license immediately revoked, are subject to a fine of up to 10 million Won (US dollars 8,400 equivalent) and/or imprisonment for up to three years. At the moment, 10 medical doctors are awaiting trial for violation of this induced abortion law.

In addition, there has been a social movement for self-regulation of medical professionals for immoral medical services such as the performance of fetal sex determination procedures. Non-governmental organizations have also campaigned on the negative effect on the sex-imbalance and improvement in social status of women.

However, it increased again in 1998 to 110.2, perhaps due to the relaxation of government restrictions and social movement against sex-selective induced abortions and/or the zodiacal sign, namely the year of the Tiger, where couples tend to avoid having a girl based on cultural beliefs[9] and hence tend to delay

9) It has traditionally been believed that a girl born in the year of the white horse would face difficulties in and bring misfortune to her life and family.

registration of a daughter perhaps to the next year.

Therefore, there needs to be continuous strengthened information, education, and communication through various mass media forums, that make people aware that if the imbalance of sex ratio at birth becomes more serious, the social and cultural aftermath and effects will only come back to them and their ancestors. There should also be continuous improvement of the social system and support policies that promote the social status of women.

Regarding the results of National Fertility Surveys, conducted every three years by the Korea Institute for Health and Social Affairs(Table 5-7), the proportion of currently married women who expressed a strong son preference through the response 'having a son(s) is quite necessary' was 47.7 percent in 1985, but decreased to 40.5 percent in 1991, and 24.8 percent in 1997.

Table 5-7 Extent of Son Preference of Currently Married Women, 1985~1997

(Unit: %, persons)

	Necessary	Better	Doesn't matter	Don't know	Total
1985[1)]	47.7	18.7	32.5	1.1	100.0(5,094)
1991[2)]	40.5	30.7	28.0	0.8	100.0(7,448)
1994[3)]	26.3	34.3	38.9	0.5	100.0(5,175)
1997[4)]	24.8	35.0	29.4	0.8	100.0(5,409)

Note: Figures for 1985 and 1991 are for ages 15~49 and those for 1994 and 1997 are for currently married women aged 15~44.

Source: Lee, Sam-sik, "Determinants of Son Preference: the Case of Korea, 1985", *Cairo Demographic Center Research Monograph Series*, 19:1004~1028, 1989.

Kong, Se-Kwon, et al., *The Family Formation and Fertility Behaviors in Korea,* Korea Institute for Health and Social Affairs, 1992.

Hong, Moon-Sik, et al., *The 1994 National Fertility and Family Health Survey*, Korea Institute for Health and Social Affairs, 1994.

Cho, Nam-Hoon, et. al., *The 1997 National Fertility and Family Health Survey*, Korea Institute for Health and Social Affairs, 1997.

However, the proportion of currently married women who responded 'having a son(s) is better' increased from 18.7 percent in 1985 to 35.0 percent in 1997. As a result, the total proportion of women expressing a son preference has been maintained at around 60 percent. Thus, although the extent of son preference has weakened, son preference still prevails in Korean society.

However, the age pattern of son preference seen in the 1997 survey implies that son preference will be gradually diluted in the future; the proportion of those who expressed 'non-son preference' is 31.1 percent for the 40～44 age group, but increased to 38.6 percent for the 35～39 age group, 40.6 percent for 30～34, and 46.4 percent for 25～29. Another implication of the weakening son preference may be found by the increase in the education level of females and accelerated urbanization in Korea, which has a negative relation with son preference(Lee, 1989).

Table 5-8. Reasons for Son Preference of Currently Married Women, 1985 and 1997

(Unit: %)

	Traditional reasons		Economic reasons		Psychological reasons		
	Carrying on family name	Rituals of ancestor worship	Old-age security	Economic ais	Psychological satisfaction	Happiness & harmony of home	Others
1985[1)]	37.3	9.1	26.1	6.6	20.3	15.6	-
1997[2)]	35.1	10.3	8.0	2.9	69.6	41.6	1.4

Note: Figures for 1985 and 1991 are for ages 15～49 and those for 1994 and 1997 are for ages 15～44 of currently married women.

Sources: Lee, Sam-Sik, "Determinants of Son Preference: the Case of Korea, 1985", *Cairo Demographic Center Research Monograph Series*, 19:1004～1028, 1989.

Cho, Nam-Hoon, et al., *The 1997 National Fertility and Family Health Survey*, Korea Institute for Health and Social Affairs, 1997.

As evident from Table 5-8, the reasons for son preference have changed from traditional and economic to psychological

reasons in Korea. The most important reason was 'carrying on the family name' which accounted for 37.3 percent among the currently married women who expressed son preference in 1985. This was followed by 'old age security(26.1%)', 'psychological satisfaction(20.3%)' and 'happiness and harmony of home(15.6%)'(Lee, 1989). However, 'psychological satisfaction' was the most prevalent reason(69.6%), immediately followed by 'happiness and harmony of home(41.6%)' while 'old age security' accounted for only 8.0 percent(Cho, 1997).

C. Policy Development for Empowerment of Women

In Korea, there has been great efforts to improve women's status. The government has prioritized policy regarding promotion of women´s rights and gender equality and equity. Particularly, the new government(1998) established the Presidential Commission on Women's Affairs(PCWA) at the ministerial level, aimed at planning, implementing, monitoring and evaluating policies related to women's empowerment and gender equality, in an integrated and effective manner.

The formulation and implementation of women's policies has been integrated into national development policies, to treat them as a critical issue, because women's presence and representation has expanded in every aspect of society and should be guaranteed equal participation in national development(Chang, 1999).

The government established the 1st Master Plan for Policy on Women's Affairs(1998～2002), which includes 20 policy priorities and 147 specific programs; these programs will be implemented by relevant ministries and local self-governing bodies while the PCWA will be responsible for monitoring implementation of the programs. According to the Master Plan, the Women's Development Fund was established in order to secure financial resources of US$ 70 million by 2001, which are

necessary to support projects aimed at advancing women's rights.

The government put efforts towards elimination of gender discrimination in employment and promotion by adopting the Equal Employment Opportunity Act and Affirmative Action. Following the recent economic crisis, female workers were laid off due to gender in the course of corporate restructuring. Hence the government revised the Labor Standard Act in 1998, prohibiting work-outs based on sex discrimination. The government has also been expanding job training opportunities for women.

Table 5-9. Trends in Low-income Single-mother Headed Households, Protected in Social Welfare Institutions by the Mother and Child Welfare Act, 1990~1998

(Unit: case)

	Total	Institutional protection	Protection at Home	Unprotected
1990	30,680	791	56	29,833
1993	26,635	919	14,540	11,176
1994	25,990	873	17,659	7,458
1995	23,527	830	20,036	2,661
1996	22,898	845	19,590	2,463
1997	22,864	847	19,764	2,253
1998	24,556	934	21,378	2,244

Source: Ministry of Health and Welfare, *Unpublished data,* 1999.

Following the economic crisis, underprivileged women, including low-income women, female-headed families, separated or divorced women, and unwed mothers have been increasing. These women and their children's urgent demands for care and welfare are not being met. Specifically, with the increase in sexual activity of adolescents and subsequently the number of unmarried mothers, the number of children abandoned by unmarried mothers

has also increased. The increase in divorces has been a main cause of the increase in abandoned children. For example, the number of single-mother headed households with low income, who are cared in the social welfare institutions by the Mother and Child Welfare Act, increased from 830 cases in 1995 to 934 cases in 1998(Table 5-9).

Korea has provided selective welfare programs for the underprivileged, based on the principle that the family has the primary responsibility and social security is secondary to family members. Emphasis has been put on strengthening the welfare function of the family and preventing the occurrence of poverty. Women's welfare policies have so far been based on a selective or residual policy, where the government intervenes only when the family and the market do not function. Therefore, women's welfare programs have been focused on childcare and the underprivileged, such as fatherless families, unwed mothers, and prostitutes.

Recently, policy has emphasized institutionalism, where welfare measures are expanded from the low income strata to women of all strata, such as in women's reproductive health and the right of adolescents, unwanted pregnancies and prevention of abortion, expansion of daycare centers for children under age 3, for the elderly including aged women with dementia and the disabled, and protection of female victims from sexual violence.

In 1989, the Maternal and Child Welfare Act was enacted to support fatherless families and unwed mothers. The Ministry of Health and Welfare implemented 'The National Health Promotion program' in 1996 and 'The 10 year program on Maternal and Child Health' in 1999, and there are plans to pay prenatal care premiums for pregnant women through National Health Insurance, starting in the year 2000. Following the economic crisis, specific programs were designed to support female headed households who face difficulty in managing their daily lives. They include government grants, such as allowances to firms which employ

female household heads and enactment of the Assistance for Women's Enterprise Act in 1999, for legal support.

The ICPD Programme of Action recommends that countries identify and condemn the systematic practice of rape and other forms of inhuman and degrading treatment of women as a deliberate instrument of war and ethnic cleansing and take steps to assure that full assistance is provided to the victims of such abuse for their physical and mental rehabilitation.

Domestic and sexual violence, especially during the economic crisis, have increased in Korea, and great efforts to eradicate them have subsequently been made. Legal reform for prohibition and prevention of sexual violence and harassment include promulgation of the Punishment of Sexual Violence and Protection of Victims Act in 1994, the Domestic Violence Punishment Special Act and the Prevention of Domestic Violence and Protection of Victims Act in 1997, and the Prohibition of Gender Discrimination Act in 1999. Sex education is also implemented in middle and high schools. In addition, the government has expanded centers for counselling on sexual-violence and protection centers for unwed mothers, and improved education programs.

D. Future Policy Directions

To promote women's status and attain gender equality, women themselves should make efforts to increase their self-esteem, change their consciousness and attitudes towards their positions, develop capability, etc.. The government should also strengthen education to help achieve the above goals. Expansion and strengthening of community-based activist groups for women are also needed, since such groups will be the focus of national campaigns to foster women's awareness of the full range of their legal rights, including their rights within the family, and to help women organize to achieve those rights.

Along with the rise in life expectancy, women have come to outlive men and the proportion of elderly women who live alone has also increased. Therefore, the government needs to design and implement programs to meet the needs of the growing numbers of elderly women who generally have a lower socio-economic status than elderly men.

The health of women has been negatively affected as their economic activities in the labor market expands, and they become overburdened by the dual-role responsibility of home and work place. Therefore, gender policy should include health and welfare services for women to promote maternity protection.

The revision of the Family Law, which is presently pending, should include legal tax exemption of inherited assets, gender-equal adjustment of marriages with related persons, gender-equal adjustment of the prohibition period of re-marriage after divorce, abolition of the distinction between own and adopted parent-children relations, and elimination of gender-discrimination in social-security related laws.

In order to empower women, efforts should be focused on the elimination of the son-preference by raising consciousness through expanded social education on gender equality of both men and women.

As female participation in economic activity increases, the government needs to enact laws and implement programs and policies which will enable employees of both sexes to organize family and work responsibilities through flexible work-hours, extended maternity leave, introduction of family and child-care leave, extension of child-care services for children under age 3 and integration of workplace child care into community based child-care. Education and publicity of male responsibilities, with respect to child-rearing and housework, need to be strengthened. In addition, the government should provide services and information to improve women's domestic working environment, which affects their health. The enhancement of women's capability is urgently needed to meet the changing socio-economic environment of the 21st century.

Chapter 6. Family Welfare

A. Change in Structure and Roles of the Family

The ICPD Programme of Action(UN, 1995) recommends that governments formulate family-sensitive policies for housing, work, health, social security and education in order to create an environment supportive of the family, taking into account its various forms and functions, and should support educational programs concerning parental roles, parental skills and child development and that governments should, in conjunction with other relevant parties, develop the capacity to monitor the impact of social and economic decisions and actions on the well-being of families, on the status of women within families, and on the ability of families to meet the basic needs of their members.

In Korea, family welfare has been most influenced by a change in structure of the family and roles of household members. As for change in the family structure, nuclearization and/or family dissolution has become more and more prevalent, mainly due to decline in fertility, migration, and increase in divorce. As can be seen from Table 6-1, the average family size(relative household) decreased from 5.7 in 1960 to 3.9 in 1995. The proportion of nuclear families increased from 72 percent in 1970 to 80 percent in 1995 and the proportion of one person households among ordinary households has also significantly increased. There has been considerable increase in the proportion of one person households compared to total general households; the proportion was 4.2 for the whole country in 1975 but increased to 12.7 percent in 1995. The increase in the proportion of one person households is greater for rural areas than for urban areas, which is a result of the high prevalence of youth-selective migration, leaving behind widowed elderly mothers(or fathers).

Table 6-1. Changes in Korean Family Structure, 1970~1995

(Unit: %)

		1970	1980	1990	1995
Average size of general households	Total	5.3	4.5	3.7	3.3
	Urban	5.1	4.4	3.7	3.4
	Rural	5.6	4.7	3.7	3.1
Nuclear families to extended families	Total	71.5	72.9	76.0	79.8
	Urban	76.9	74.7	77.6	80.9
	Rural	67.6	70.3	71.3	75.9
1 person households to general households	Total	4.2[1)]	4.8	9.0	12.7
	Urban	4.5[1)]	4.7	8.6	11.8
	Rural	3.9[1)]	4.9	10.3	15.6

Note: 1) Figures are for 1975.
Source: National Statistical Office, *Population and Housing Census Report*, each year.

Regarding the roles of the family, as women's participation in economic activities increases, either for career or family support, the less time they can afford to commit to housework and childcare. Although gender roles for males and females have been changing, women, regardless of their employment in outside work, are still responsible for the majority of housework and childcare. The multiple role of women for household work, child-care, and work often causes disruption, family conflicts and dissolution.

Thus, the Korean government has put great effort towards preventing family dissolution and protecting vulnerable people undergoing family dissolution. The government has supported and assisted those vulnerable families, which includes single-mother families, dependent elderly households (single elderly or couples), families with disabilities, etc., in order to prevent family dissolution or further dissolution and to guarantee family welfare. Efforts by the government also include the strengthening of protection and

welfare for abandoned and abused people, through qualitative and quantitative improvement of social welfare institutions. The number of social welfare institutions for children decreased from 303 in 1980 to 272 in 1998, due mainly to the decrease in the total number of children, which is a result of the decline in fertility.

Legal reform has been made in effort to prevent family dissolution as well as to increase family welfare. For example, the Livelihood Protection Act was revised in 1997, to broaden protection coverage and increase support for these families. An act for enforcing welfare for the disabled and aged was also enacted in 1997. The revision of the Special Adoption Act in 1995 is aimed at strengthening the rights and welfare of adopted children.

B. Impact of the Economic Crisis on Family Welfare

The impact of the recent economic recession on family welfare must also be discussed, because of the immediate effect that the recent economic crisis has had on the family. First of all, the rise in the number of impaired families, with the increase in unemployment of household heads, has resulted from more divorces. As can be seen from Table 6-2, the number of divorces increased from 80.0 thousand cases in 1996, prior to the economic crisis, to 123.7 thousand cases in 1998 or by 54.6 percent, which also resulted in increase in abandonment of homes by wives.

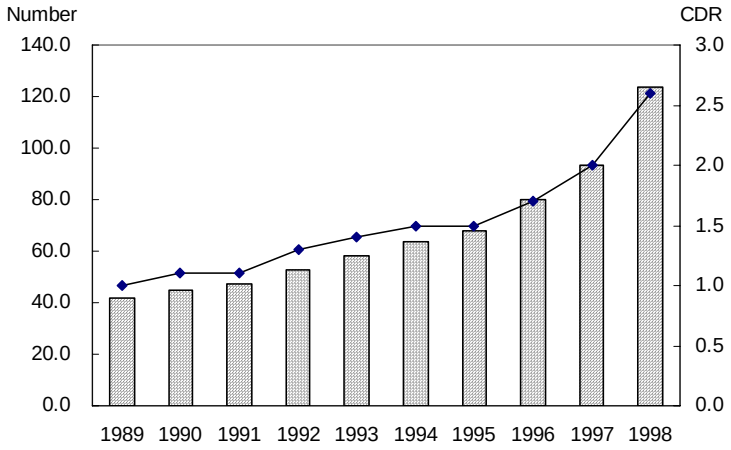
Table 6-2. Number of Divorces and Crude Divorce Rate(CDR), 1989~1998

(Unit: 1,000 cases, per 1,000 people)

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Number	42.1	45.0	47.4	52.6	58.3	63.9	68.1	80.0	93.3	123.7
CDR	1.0	1.1	1.1	1.3	1.4	1.5	1.5	1.7	2.0	2.6

Source: National Statistical Office, *Report on Vital Statistics,* 1999.

Figure 6-1. Trends in No. of Divorces(in thousand) and CDR(%) in Korea



There has been an increase in the number of cases where children or elderly persons that are difficult to care for are abandoned or put into nursing homes. In case of children, the number of abandoned children increased from 1,276 in 1996 to 1,654 in 1998 or 29.6 percent, as presented in Table 6-3. The total number of needy children including abandoned children, run-away children, missing children, and children from unwed mothers, increased from 4,951 in 1996 to 9,292 in 1998 or by 87.7 percent. According to a survey conducted by the Korea Institute for Health and Social Affairs & Korea Labor Institute(1999), households with a person who has run away or abandoned their family comprises 5.2 percent of total households and a major proportion of these left because of financial difficulties or because of family discord resulting from those difficulties.

Table 6-3. Trends in Occurrence of Needy Children, 1990~1998

(Unit: persons)

Year	Total	Type of Occurrence				Type of Protection			
		Abandoned	From unwed mothers	Missing	Run-away	Institutional care	Foster	Adoption	Child-headed family protection
1990	5,271	1,844	2,369	360	1,148	3,734	1,134	853	-
1991	5,095	1,610	2,020	188	1,277	3,414	999	682	-
1992	5,020	1,481	1,813	241	1,485	3,122	1,212	686	-
1993	4,451	1,330	1,904	137	1,080	2,940	943	568	-
1994	5,023	1,386	1,781	192	1,664	2,953	927	760	383
1995	4,576	1,227	1,285	149	1,915	2,819	505	472	780
1996	4,951	1,276	1,379	189	2,107	3,161	727	479	584
1997	6,734	1,372	1,833	342	3,187	3,917	1,209	898	710
1998	9,292	1,654	4,120	277	3,241	5,112	2,353	1,283	544

Note: Child-headed family protection was not classified prior to 1994.
Source: Ministry of Health and Welfare, *Report on Health and Welfare Statistics*, each year.

Domestic violence and child abuse has also increased. A portion of household heads have become homeless[10], which has also exacerbated family dissolution. In addition, there has been a rapid increase in misconduct such as increase in crimes of necessity, suicide rate, addiction to alcohol, drugs, etc., and increase in misconduct of housewives out of necessity (Chung, 1999). Protection of vulnerable people, such as children, the elderly and disabled in the family, is inadequate because of unemployment or bankruptcy of household heads, which results in housewives becoming economically active or abandoning their family.

10) As of late September 1998 there was a total of 2,550 homeless persons in Seoul, and it is estimated that there are 6,000 homeless persons nationwide. If the latent homeless who have no fixed place to sleep are included, it is estimated that there are 50,000 homeless persons nationwide.

Employment is of utmost importance to protect the family from dissolution and improve the health and welfare of the population, specifically the underprivileged. Thus, the government has made efforts in two directions; reducing the unemployment rate through creation of jobs and establishment of a social safety net.

Policy measures aimed at decreasing unemployment include short-term projects that are comprised of work sharing projects, income sharing projects, and long term projects which emphasize the importance of educational reform. Work sharing projects include economic vitalizing projects(building of social overhead capital, consumer financing, adoption of the credit guarantee system, support for venture capital and small and medium sized firms); direct supply of job opportunities(public work projects); support for creation of job opportunities(support for avoidance of discharge or layoff, subsidy for new hiring, adoption of internships for new graduates from high schools or colleges and over); and enhancing the employment probability of employees (preparation of the unemployed database, improvement of on-the-job training projects). Income sharing projects include the employment insurance project, loans for the unemployed, building up the social safety net for the low income group(poverty line), and subsidies for school fees of the unemployed. As of February 28, 1999, the government has planned to allocate 16 trillion Won for the various projects mentioned above.

In addition, the framework for a social safety net was provided with expansion of the National Pension Scheme to the entire population in April 1999. On a temporary basis, the government has focused on local governments by managing and increasing homeless centers, implementing policies that lead the homeless back to their homes, and by developing the management of free cafeterias in the private sector.

However, the average income of households with unemployed household heads is 32 percent of urban laborers, whereas the income of households with no employed persons is only 16.1

percent. 61 percent of unemployed households whose income is below the minimum cost of living. The role that the government takes in public programs is still inadequate, and the provision of living expenses is reliant upon labor income, savings, retirement funds, and private assets of other households. A considerable amount of unemployed households, 18.0 percent, receive help from relatives or neighbors(Survey on Status of the Unemployed and Demand for Welfare, Korea Institute for Health and Social Affairs and Korea Labor Institute, 1999)[11].

Therefore, the government has made further efforts to improve family welfare, specifically of the underprivileged; including adoption of 'productive welfare' and promulgation of the Basic Livelihood Security Law.

C. Future Policy Directions

The stability of the family, as a basic unit of society, is of utmost importance in sustaining a healthy society. Support and assistance for the family should be given higher priority in the government's policies, specifically following the economic crisis to prevent family dissolution and ensure family welfare.

As urged by the ICPD Programme of Action, the government should develop innovative ways to provide more effective assistance to families and the individuals within them who may be affected by specific problems, such as extreme poverty, chronic unemployment, illness, domestic and sexual violence, drug or alcohol dependence, and child abuse, neglect or abandonment.

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11) More than half of unemployed(57.7 percent) households received schooling subsidies and 17.7 percent of the children whose household head was unemployed experienced deterioration of their academic performance in school. 5.2 percent of the unemployed had experienced run away of household members, and 1.4 percent had experienced disharmony among household members.

The government needs to support and develop the appropriate mechanisms to assist families with children, dependent elderly and family members with disabilities, encourage the sharing of those responsibilities by both men and women, and support the viability of multi-generational families.

Specifically, policies and plans should pay special attention to vulnerable groups, including single-parent families, including single-mother and single-father households, widows, abandoned children, and the elderly without economic support. In order to protect the family from the impact of the economic crisis and thereby recover social stability, special countermeasures, including the establishment of a social safety net, are needed.

During an economic crisis, the poor stand to suffer the most - especially from irreversible losses in potential education and health that will impede their participation in future recovery. High priority should be given by governments, non-governmental organizations and the private sector to meet the needs, and increase opportunities for information, education, jobs, skill development and relevant reproductive health services of all underprivileged members of society. Measures should be taken to improve food and nutrition, with special attention given to the creation and strengthening of food security at all levels. Special efforts should be made to create productive jobs, through policies which promote efficient and, where required, labour-intensive industries, and transfer of modern technology. Efforts to maintain purchasing power will help, but education measures are needed to focus on keeping schools and health care affordable for poor households and quality of services intact.

Finances should be ensured for the successful implementation of the Basic Livelihood Security Law, which was enforced in 1999. The main aim of this law is to secure the basic livelihood of all households below the poverty line, which includes security of the basic livelihood for households without working ability and support, by their level of work, for low-income households with working ability. Related research should also be performed.

Chapter 7. Population Ageing and Elderly Welfare

A. Population Ageing and Challenges

Life expectancy has increased in Korea, resulting in accelerated population ageing and increase in the number and proportion of the elderly aged 65 or over, especially elderly women. As presented in Table 7-1, the life expectancy increased from 52.4 years for both sexes in 1960 to 74.4 years in 1997(NSO(a), 1999). According to projections(NSO, 1996), it will increase to 78.1 years in 2020.

Table 7-1. Trends in Life Expectancy, 1960~2020

(Unit: years)

	1960[1)]	1970[1)]	1977[1)]	1985[1)]	1991[1)]	1997[1)]	2000[2)]	2020[2)]
Both sexes	52.4	63.2	64.5	68.4	71.7	73.4	74.9	78.1
Male	51.1	59.8	60.8	64.5	67.7	70.6	71.0	74.5
Female	53.7	66.7	68.7	72.8	75.9	77.1	78.6	81.7
Difference	2.6	5.9	8.0	8.3	8.2	7.6	7.6	7.2

Sources: National Statistical Office, 1971~1997 Life Tables for Korea,1999.
National Statistical Office, Future Population Projection, 1996.

As influenced by the rise in life expectancy, the proportion of elderly to the total population(Table 7-2) increased 3.1 percent in 1970 to 6.8 percent in 1999. Although the proportion is lower, compared to more developed countries(over 10 percent), the speed of population ageing is unprecedented in that the proportion of the elderly 65 and over in Korea will be 7 percent in 2000 and 14 percent in 2022. The duration for this transition will only be

22 years in Korea, but was 115 years for France, 75 years for USA, and 26 years for Japan(see Table 7-3).

Table 7-2. Trends in Population Structure, 1970~2030

(Unit: %)

	Population structure			Elderly(%)		
	0~14	15~64	65+	65~69	70~79	80+
1970	42.5	54.4	3.1	1.3	1.4	0.3
1975	38.6	58.0	3.4	1.5	1.5	0.4
1980	34.0	62.2	3.8	1.6	1.7	0.5
1985	30.2	65.6	4.3	1.7	2.0	0.5
1990	25.6	69.3	5.1	2.1	2.3	0.7
1995	23.4	70.7	5.9	2.3	2.7	0.8
1999	21.8	71.4	6.8	2.7	3.1	1.0
2000	21.6	71.2	7.1	2.9	3.2	1.0
2005	21.2	70.1	8.7	3.5	3.9	1.3
2010	19.9	70.1	9.9	3.5	4.8	1.5
2015	18.4	70.3	11.3	3.9	5.4	2.0
2020	17.2	69.6	13.2	4.8	5.8	2.6
2025	16.4	67.3	16.3	6.4	7.0	2.9
2030	16.0	64.7	19.3	6.7	9.2	3.4

Source: National Statistical Office, *Future Population Projection,* 1996.

Table 7-3. International Comparison of Years to Reach from Elderly Proportion of 7 to 14 Percent

Country	Years to reach elderly proportion of 7% to 14%		Difference (Years)
	7 percent	14 percent	
Korea	2000	2022	22
Japan	1970	1996	26
USA	1945	2020	75
France	1865	1980	115

Source: Cho, Namhoon, et. al., *Recent Population Dynamics and Future Policy Directions,* Korea Institute for Health and Social Affairs, 1998.

With the rapid progression of population ageing, the number of elderly who suffer from chronic diseases and dementia, and who are bed-ridden, also increases. In 1995, the elderly chronic disease rate was 10.5 percent, compared with 4.3 percent of the total population, and the proportion of the elderly with limitations in activities of daily living(ADL) was 150 thousand, or 5.6 percent of the total elderly. Accordingly, the utilization of medical facilities and medical costs of the elderly has increased. Medical care costs have increased 35.5 times during the past 10 years, although costs for the total population have only increased 12.7 times in the same period, which is experienced by more developed countries.

Table 7-4. Economic Participation Rate of the Elderly, 1970~1998

(Unit: thousand persons, %)

	Aged population			Economic participation rate		
	Total	Male	Female	Total	Male	Female
	For persons aged 60 or over					
1970	1,704	700	1,004	25.9	41.7	14.8
1980	2,543	1,023	1,520	28.3	45.1	17.0
1985	3,013	1,207	1,806	29.3	44.3	19.3
1990	3,598	1,412	2,186	35.6	49.8	26.4
1995	4,145	1,657	2,488	41.9	58.4	30.9
1997	4,554	1,849	2,705	43.5	59.9	32.3
1998	5,106	2,126	2,980	38.1	52.2	28.1
	For persons aged 65 or over					
1990	2,363	876	1,487	26.1	39.3	18.4
1995	2,881	1,084	1,797	28.5	41.5	20.6
1997	3,204	1,216	1,988	30.2	42.4	22.8
1998	3,221	1,217	2,004	27.7	40.4	19.9

Source: National Statistical Office, *Economically Active Population Survey*, each year.

As can be seen from Table 7-4, the economic participation rates for the elderly aged 60 years or over and 65 years or over have gradually increased, with exception of 1998 when the impact of the economic crisis resulted in a lowered rate in comparison with that for the previous year. However, the economic participation of the elderly, specifically the female elderly, is insignificant. Despite the rise in life expectancy, the retirement age is relatively low, which has resulted in the low economic activity of the elderly, low economic self-support ability for old-age security, and insufficient utilization of elderly manpower, etc.

B. Policy Advancement for Elderly Welfare

The Elderly Welfare Act was revised in 1995 to strengthen the health care and welfare of the elderly. Based on this act, the number of social welfare institutions for the elderly increased to 200, the number of home-helpers dispatch institutions to 52, the number of day-care institutions to 31, and the number of short-term care institutions had increased to 15 at the end of 1998. The home nursing helper system was also introduced in 1999.

The National Pension Scheme has been implemented since 1988 for old age security. However, the people who became old in the past were excluded from scheme benefits. Therefore, the introduction of old-age pension in 1998 made possible the security of low-income elderly, who are not covered by the National Pension Scheme. The provision for these elderly by the National Pension is insufficient to secure their livelihood. As of August 1998, the old-age pension covered a total of 623 thousand elderly, including 249 thousand elderly under Livelihood Protection and 375 thousand low-income elderly, who account for 20.4 percent of the total elderly. The average amount of money received is 50 US dollars for Livelihood Protection elderly 80 years of age or over, 40 US dollars for Livelihood Protection

elderly 65 to 79 years of age, and 20 US dollars for low-income elderly.

In Korea, elderly care has traditionally been the family's duty but has changed to the duty of the society and country. Although national health insurance covers the entire population, this scheme mainly covers curing of diseases. Hence, the elderly, who are more in need of care than cure due to the high rate of chronic degenerative diseases, cannot benefit from this scheme.

C. Future Policy Directions

All levels of government should take into account the increasing numbers and proportion of elderly people in mid- to long-term socio-economic planning. The government should develop social security systems that ensure greater inter- and intra-generational equity and solidarity, that provide support to elderly people through encouragement of multi-generational families, and the provision of long-term support and services for the growing number of frail elderly.

The government should seek to enhance the self-reliance of elderly people to facilitate their continued health. The necessary conditions should be developed to enable elderly people to lead self-determined, healthy and productive lives and to make full use of the skills and abilities they have acquired in their lives, for the benefit of society. The valuable contribution that elderly people make to families and society, especially as volunteers and caregivers, should be given due recognition and encouragement. The government should strengthen formal and informal support systems and safety nets for elderly people and eliminate all forms of violence and discrimination against elderly people.

A welfare community connecting family, neighbours, communities, and government should be established to meet the demand for elderly welfare. As a welfare community, the Korean

government is responsible for meeting the basic needs of the elderly, and the family and community are responsible for the other needs of the elderly.

The government should make efforts to secure the basic livelihood of the low-income elderly. This includes increasing the living costs paid to the poor elderly under Livelihood Protection to secure their minimum livelihood, coverage expansion of elderly people by Old-age Pension, with increase in the amount of payment from the current level of 20 to 50 thousand Won per month.

The number of jobs for the elderly should be increased from the current number of 60 and, in the future, the employment of a certain proportion of the elderly in these jobs should be regulated by the government and private sectors. The government should increase subsidies for the promotion of elderly employment, which is provided by the employment insurance fund, to firms which have 6 percent of their employees consist of the elderly, from the current 30 thousand Won per person to 50 percent of the minimum wage level.

The government should make efforts to improve the medical and health security of the unhealthy elderly. The items(12 items for primary examination and 30 items for secondary detailed examination) covered by free health examinations, which are provided to the Livelihood Protection elderly under the Elderly Welfare Act, should include cancer and dementia. The examination results should be reported to the elderly themselves and the public health center, which is responsible for caring for the elderly within its jurisdiction. The roles and functions of the public health centers should be strengthened with professional manpower support and equipment so that they can serve as a primary diagnosis institution for management of chronic diseases of the elderly in the local community.

Existing rehabilitation institutions should be classified according to the elderly people's disease and health status. This

will enable institutions to provide professional services for the elderly. The system and law should also be reformed so that these institutions may receive benefits from Health Insurance.

Complexes and counselling centers for the elderly with dementia should be put into operation. Complexes for the elderly with dementia should function to develop technology of prevention, diagnosis and treatment of dementia, to establish a local health information network for dementia patients, and to train nurses, medical doctors and counselors. In the meantime, a center for dementia counseling needs to be established in public health centers, to provide guidelines and information on dementia. Also, professional institutions for care of the elderly with severe dementia should be expanded.

In order to increase the participation of the elderly in social activities, volunteering by them should be encouraged by adopting an insurance scheme and system of elderly volunteers, developing areas to be served by elderly volunteers and maximizing utilization of them in areas such as environment inspectors, traffic violation inspectors, protectors of nature and cultural relics, etc,. Facilities for elderly leisure should be expanded with advanced equipment and programs should be diversified to meet the increasing demands of the elderly.

Elderly welfare of those at home should be strengthened. There were 2,683 service centers established for home-care elderly per middle school enrollment area(boundary), in 1995. The aims of the center are to identify the status and needs of the elderly, provide nursing care, counseling and other related services for home-care elderly, and provide necessary information. Securing home-helpers will be of utmost importance when expanding the centers. The current home-helpers should be classified into those home-helpers who provide home services and psychological and social services, and home-nursing helpers who provide nursing services. The fee-based home-helper system needs to be adopted for the middle and upper classes[12].

Daycare and short-term facilities should be expanded to provide medical services to the elderly, by revising the Elderly Welfare Act. The Silver Line should also be established to provide complex information and counseling services on health, medical care, welfare, etc,. This information and service network needs to be linked to various institutions for the elderly so that they may be provided information on social welfare institutions. Also, the elderly emergency information system needs to be established.

In implementing the above programs and policies for the welfare of the elderly people, the necessary finances should be secured. For preparation of population ageing in the near future, policy needs to be shifted from 'low burden and low benefits' to 'optimum burden and security of the low-income elderly'. In comparison with other countries, the proportion of the budget appropriated for social welfare is very low; only 0.14 percent of the total government budget in 1997 was allocated for elderly welfare in Korea, whereas in Japan it was 3.4 percent and 33.5 percent in USA in 1995. Civil societies, including non-governmental organizations, non-profit corporations, religious organizations, and firms should be recommended and encouraged to participate in the government's programs for elderly welfare. The government should support and assist silver industries and programs for elderly welfare at home through tax-exemption, loans, etc.

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12) Currently, only the Korea Association of Old-age Welfare and the Institute of Newspaper Women and Women Educators have adopted the fee-based home-helper system.

Chapter 8. Population, Development and Environment

A. Evolution of Sustainable Development

The ICPD Programme of Action(UN, 1995) recommends that the government formulate and implement population policies and programs to support the objectives and actions agreed upon in Agenda 21, other Conference outcomes and other international environmental agreements, taking into account the common but differentiated responsibilities reflected in those agreements.

In Korea, the government has put high priority on economic development since the early 1960s, resulting in rapid growth of the industries that consume excessive amounts of energy and emit pollution(refer to Table 8-1). Rapid economic development, concomitant with industrialization and urbanization, and growing population have aggravated environmental deterioration. Therefore, the Ministry of Environment was newly established in 1980 in response to the need for design, implementation, monitoring and evaluation of policies related to the environment in an integrated and efficient manner.

In 1996,「Environment Vision 21」was set up as a long term plan for environment preservation and the Second Medium Complex Plan for Environment Improvement was established to implement the Vision 21. The Vision for Environmental Welfare, as adopted in March 1996, puts high priority on the environment when establishing and implementing all policies, adopts environment-friendly production methods that increase compatability between economic development and environmental preservation, establishing an environment-friendly life style, integrating efforts of the people in solving environmental problems, increasing

cooperation for environment preservation between South Korea and North Korea, and fully considering environmental safety in all areas of life.

Table 8-1. Major Socio-economic Indicators Related to Population, Development and Environment, 1970～1998

	1970	1980	1990	1995	1998
Population(thousands)	30,882	37,407	43,390	44,554	46430
Pop. Distribution(percent)					
Seoul	17.6	22.3	24.4	22.9	21.8
Capital area[1)]	28.3	35.5	42.8	45.2	45.9
7 Metropolises[2)]	32.5	42.7	49.1	50.0	48.9
Pop. Density(Persons/㎢)	328	378	437	449	467
Urbanization rate(%)	41.1	57.2	74.4	78.5	-
Industrial structure(%)					
Primary	-	34.0	17.9	12.5	11.0(97)
Secondary	-	22.5	27.6	23.6	21.4
Tertiary	-	43.5	54.5	64.0	21.3
GDP(billion Won)	27,849	62,817	161,785	236,651	

Note: 1) including Seoul, Inchon and Kyonggi-do.
2) including Seoul, Pusan, Taegu, Inchon, Kwangju, Taejon, and Ulsan.
Source: National Statistical Office, *Social Indicators in Korea,* 1998.

The Second Medium Complex Plan for Environment Improvement(1997～2001) is aimed at strengthening the roles of local autonomies and to increase their capability for environmental management, as the central government cannot alone meet the diverse environmental demands of all regions. The objectives of the Plan are prevention of environmental degradation, integration of development and environment preservation, payment of environmental costs by users of environmental resources and producers of pollution, provision of environment-related

information, and increasing people's participation in environmental policies.

The ICPD Programme of Actions stresses that the government modify unsustainable consumption and production patterns through economic, legislative and administrative measures, as appropriate, aimed at fostering sustainable resource use and prevention of environmental degradation. In order to adopt environment-friendly production methods and life style, the Korean government restricts consumption of solid fuel and increases provision of low sulfur coals, replaces coals and B-C fuels to urban gas, improves methods and facilities of burning, and regulates equipment for prevention of industrial dust. In 1977, a regulation on volatile organic chemistry was enforced to reduce harm to residents in industrial complex areas. Since 1995, the number of firms which have voluntarily adopted environment-friendly production methods, based on the 「Regulation of Management of Environment-Friendly Firms」, has increased.

In order to induce consumption which protects the environment, the volume-base garbage collection system was enacted throughout the country in 1995. It has been regulated that public facilities that recycle food wastes to produce fodder, compost, etc. be established per Shi · Gun area, especially in housing and tourism complex areas. Restricted use of disposal commodities, which started since 1993, has been reinforced from 1995, extending the firms and commodities that are to be restricted. As a result, the amount of household waste, as presented in Table 8-2, decreased from 1.8㎏ per day and person in 1992 to 1.1㎏ in 1996. Food waste has only decreased from 0.46㎏ per day/person in 1994 to 0.35㎏ in 1996 or by 23.9 percent. Specifically, the proportion of recycling of waste to all waste, including both industrial and household waste, increased from 29.8 percent in 1992 to 48.9 percent in 1995. Recently, the use of vinyl packaging has been restricted.

The Regulation on Air Environment Preservation, which was revised in 1995 and again in 1996, strengthened criteria on pollution discharge of newly produced cars and recall system, and guaranty period.

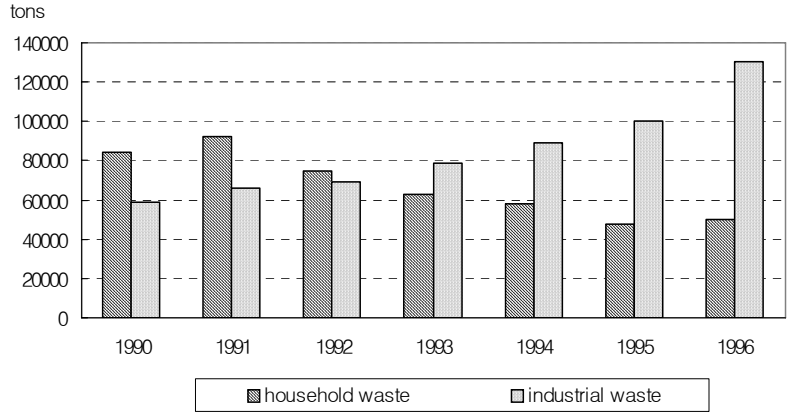
Table 8-2. Trends in Waste, by Type, 1990~1996

(Unit: tons per day)

	1990	1991	1992	1993	1994	1995	1996
Total	142,721	158,376	144,535	141,383	147,049	148,041	180,573
Household waste	83,962	92,246	75,096	62,940	58,118	47,774	49,925
Industrial waste	58,759	66,130	69,439	78,443	88,931	100,267	130,648
Household waste per day/person(Kg)	2.3	2.3	1.8	1.5	1.3	1.1	1.1

Source: Ministry of Environment, *Environment White Paper*, 1998.

Figure 8-1. Trends in Waste in Korea



The concentration of the population into metropolitan areas and industry complexes(cities) has caused subsequent increase of environmental pollution. In response, the criterion for the

proportion of sulfur contained in oil fuels decreased from 41.6 percent for B-C oil and 0.4 percent for gasoline(light oil) in 1981 to 1.0percent and 0.1percent in 1996; the provision of fuels, based on this criterion, has gradually expanded to all metropolitan areas and industrial sites. LNG should be used in cities where the level of pollution exceeds the criterion. As a result, although there has been a great increase in consumption of fuel, the amount of air pollution decreased from 5,169 thousand tons in 1990 to 4,425 thousand tons in 1996. As can be seen in Table 8-3, the pattern of air pollution in Korea has changed from sulfurous acid gas and dust, which are often predominant in developing countries to nitrogen dioxide, usually predominant in developed countries; this shift is due mainly to the increase in number of cars.

Table 8-3. Trends in Air Pollution by Type, 1990~1996

(Unit: thousand tons)

	1990	1991	1992	1993	1994	1995	1996
Total	5,169	4,870	4,878	4,584	4,526	4,350	4,425
Sulfurous acid gas	1,611	1,598	1,614	1,572	1,603	1,532	1,500
Nitrogen oxide	926	878	1,067	1,187	1,192	1,153	1,258
Dust	420	431	392	390	430	406	424
Carbon monoxide	1,991	1,760	1,630	1,291	1,156	1,109	1,089
Hydrocarbon	221	200	164	145	146	150	154

Source: Ministry of Environment, *Environment White Paper*, 1998.

Various policies to protect residents, in industrial sites, from environmental deterioration have been adopted. For example, the use of volatile organic chemistry has been restricted and establishment of facilities for pollution prevention in industrial sites has been regulated since 1997. The government has established Ecology Preservation Areas, where all development is restricted, and supports residents who are disadvantaged by

development restrictions.

The ICPD Programme of Action(UN, 1995) recommends that research be done on the links between population, consumption and production, the environment and natural resources, and human health as a guide to produce effective sustainable development policies. In Korea, numerous research on integration of population, consumption and production, environment and natural resources, and people's health has been performed by research institutes and universities and their output has been included in the establishment of environment related policies. Specifically, there have been efforts to improve environment statistics. In 1997, a long term plan for developing environment statistics was established. The method of compiling environment statistics shifted from arrangement of management cases to an impact-status-response system of OECD, which will enable policies and plans to integrate the environment with population, social and economic factors.

The ICPD Programme of Action(UN, 1995) recommends that measures be taken to enhance the full participation of all relevant groups, especially women, at all levels of population and environmental decision-making to achieve sustainable management of natural resources. As a legal effort, the Korean government promulgated the 「Law for Evaluation on Environmental Influenc e」 as an independent law in 1993. This law was revised in 1997, mainly to strengthen residents' participation in evaluation of the impact of environmental preservation to reconcile conflicts between firms and residents.

The government has promoted education and awareness activities of environment problems for public awareness. Environmental education is divided into school and social education; in school education, environmental issues are included in the curricula of primary, middle and high schools in the 6th curricula from 1992 to 1996 and the 7th curricula from 1997 to 2001. The number of schools adopting environment issues in their curriculum increased from 50 in 1996 to 311 in 1997 in middle

schools and from 131 in 1996 to 164 in 1997 in high schools. Establishment of departments related to environment in universities has been increasing.

NGOs related to environment issues also increased in number to 371 in 1997 with the rise in people's interest in and demands on the environment. NGOs, in which experts, women, religious groups. etc., participate, hold seminars on the environment and perform publicity activities through mass-media, publications, tapes, etc. Specifically, a meeting for environment related leaders around the world was held and the Seoul Declaration was adopted in June 1997.

B. Future Policy Directions

Environment policies in Korea have had the tendency to implement after-the-fact cures for the impact of demographic factors on the environment, rather than prevention of environment degradation by the population. Consistent with the framework and priorities set forth in Agenda 21, the government needs to achieve population and environment integration. Demographic factors should be integrated into environment impact assessments and other planning and decision-making processes aimed at achieving sustainable development. In Korea, population concentration in metropolitan areas, specifically the capital area including Seoul, Inchon and Kyonggi-do(province), has been and will be a critical obstacle to not only socio-economic development, but also environmental improvement and eventually improvement in quality of life.

Policies must be implemented to address the ecological implications of the inevitable future increase in population and changes in concentration and distribution, particularly in ecologically vulnerable areas and urban agglomerations. In particular, the policy for decentralization of the population in the

capital area should be continued with more special attention and effective measures. Although population growth is an important factor for the environment in Korea, it has been maintained at a low level, population policy must take into consideration other development factors, in addition to the environment. This integration of population, development and environment will eventually lead to welfare of human beings.

Under the recent economic recession, it was required that the government take measures aimed at the eradication of poverty, since the life style of low-income classes living within or on the edge of fragile ecosystems may be harmful to the environment. Special attention and policy measures against environmental degradation should be given to areas where low-income classes are concentrated.

Since 1985 when local autonomies were started, it was expected that transferring environment administration authority from the central government to local autonomous entities would be more effective for the implementing of related policies, by reflecting the situations of each region. However, regional development plans have often been given higher priority than environment preservation, which resulted in environmental degradation. Therefore, it is necessary that the central government make a comprehensive evaluation on the difference between development benefits and its impact on environment and welfare of population and, on this basis, make a rational decision. Specifically, a model for environment friendly development should be developed and provided for local governments.

Environment-friendly production and consumption should be reinforced. As income rises, consumption patterns change giving way to more waste and the growing demand for leisure leads to development of golf courses, condominiums, and other leisure facilities, which are main causes of environment degradation. Therefore, efforts to improve the quality of life should be made within sustainable development.

Chapter 9. Population Distribution, Urbanization and Migration

A. Population Distribution and Policy Measures

1) Internal Migration and Population Distribution

As can be seen from Table 9-1, the migration flow in Korea has been characterized by excessive rural-to-urban migration during the early phase of development and predominant urban-to-urban migration, since the 1980s, after the significant depletion of youth in rural areas due to migration selectivity. Such migration flows have resulted in an excessively high concentration of population in large cities(metropolitan cities), specifically the capital area including Seoul, Inchon and Kyonggi-do(province). The most important reasons for moving from rural area to urban area have been education, job- and family-related affairs(Lee, 1991).

Table 9-1. Trends in Migration Flows, 1965~1995

(Unit: thousand persons, %)

	1965~70	1970~75	1975~80	1980~85	1985~90	1990~95
Total	4,395(16.2)	5,151(16.9)	7,618(22.7)	8,366(22.8)	9,816(24.5)	10,088(24.5)
R→U	1,827(11.5)	1,754(11.1)	2,524(17.4)	2,424(18.9)	2,329(22.3)	1,232(13.1)
U→U	1,532(13.6)	2,257(15.5)	3,855(20.1)	4,584(19.2)	6,376(21.5)	8,009(24.0)
U→R	387(3.4)	558(3.8)	681(3.6)	889(3.7)	743(2.5)	694(3.1)
R→R	649(4.1)	563(3.6)	558(3.9)	469(3.7)	368(3.5)	153(2.4)

Note: 1) ( ) is migration rate.
Source: National Statistical Office, *Population and Housing Census*, each year.

Such flows in migration movement, together with expansion of urban areas and reclassification of rural areas into urban areas, have accelerated urbanization in Korea. The urbanization rate, which is denoted as the proportion of population in urban areas(Dongs in cities including metropolitans) to the total population are in Table 9-2, increased from 28.0 percent in 1960 to 78.5 percent in 1995.

Table 9-2. Trends in Urbanization Rate, 1960~1995

(Unit: %)

Year	1960	1970	1980	1985	1990	1995
Rate(%)	28.0	41.1	57.2	65.4	74.4	78.5

Source: National Statistical Office, *Population and Housing Census*, each year

As aforementioned, the migration flow resulted in an excessive concentration of population into a few large cities. As revealed in Table 9-3, the population concentrated in capital areas in 1995 accounted for 45.3 percent of the whole population and the population in Seoul accounted for 22.9 percent. Such a high imbalance in population distribution has had a serious socio-economic impact, which has in turn become a barrier to further balanced development. For example, overcrowding in urban areas led to lack of urban facilities such as housing, roads, etc., increase in pollution and environmental degradation, heavy traffic, crime, and unemployment, etc. In rural areas, there is a lack of agricultural labor force due to selectivity of migrants, namely the young, which has accelerated ageing of the rural population and hence ageing and feminization of the agricultural labor force.

Table 9-3. Trends in Population Distribution, 1960~1995

(Unit: thousand persons, %)

	1960	1980	1990	1995
Whole country	24,989	37,436	43,411	45,093
Seoul	2,445	8,364	10,613	10,342
Kyonngi-do	2,749	4,934	6,156	7,738
Capital area	5,194	13,298	18,587	20,414
Seoul(%)	9.8	22.3	24.4	22.9
Kyonggido(%)	11.0	13.2	14.2	17.2
Capital area(%)	20.8	35.5	42.8	45.3

Note: The capital area includes Seoul, Inchon and Kyonggi-do.
Source: National Statistical Office, *Report on Population and Housing Census*, each year.

Table 9-4. Concentration of Socio-economic, Administrative and Other Functions in the Capital Area, 1995

	Whole country	Capital Area(%)
Area(㎢)	99,394	11,726(11.8)
Population(thousand)	44,609	20,189(45.3)
Population density(per/㎢)	449	1,722
Housing supply ratio(%)	86.1	76.5
GRDP(billion Won)*	305,974	141,446(46.2)
Establishments(each)*	167,403	96,964(57.9)
Manufacturers(each)*	91,327	50,810(55.6)
Savings(billion Won)	154,136	99,804(64.8)
Financial loans(billion Won)	152,477	90,409(59.3)
Universities	131	55(41.9)
Public agencies	513	419(81.7)
Corporation headquarters	100	88(88.0)
Research institutes	2,248	1,540(68.5)

Note: The capital area includes Seoul, Inchon and Kyonggi-do.
* is for 1994.
Source: Park, Sang-Woo, et al., "Future Directions for Improvement of Policies for Rearrangement of the Capital Area", *Policy Directions for Development of Land in the 21st Century:* pp. 77~85, Korea Institute for Development of National Land, 1998.

Also, population concentration into the capital area and metropolitan cities has expedited high concentration of manufacturers, finance and insurance establishments, public institutions and other social, economic, cultural and administrative facilities into these areas, specifically in the capital area. For example, as of 1995, 55.6 percent of manufacturers, 59.3 percent of financial loans and 81.7 percent of public agencies were concentrated in the capital area(presented in Table 9-4). Thus, high concentration of population into the capital area has increased social expenditures and widened disparities in development level between areas, which has often been linked to political and social issues.

Progress was made in the 1990s in population decentralization. Seoul and Pusan, the two biggest cities(metropolitans), have witnessed excessive out-migration, implying that the absolute size of their population has decreased. This reverse phenomenon in migration flow has been seen in the other five metropolitan areas since 1992. The net number of migrants, where the volume of out-migration is greater than that of in-migration, is becoming larger with time.

Specifically, following the recent economic recession, the population who became unemployed during economic restructuring, have increasingly migrated, with their family members, to rural areas; the government has supported, financially and technically, the return of migrants to settle themselves in rural areas. Since 1990, there have been 13,595 households that have returned to rural areas, specifically 47.1 percent(or 6,409) of these households returned after the economic recession(Ministry of Agriculture, 1999). It is noteworthy that 89 percent of household heads who are return migrants, are under age 40, which may help alleviate the lack and ageing of labor force in rural areas.

However, Inchon metropolis and Kyonggi-do, which surround Seoul, have continued to absorb the population from Seoul and other areas, including rural areas. Thus, despite the decrease in

Seoul population, the population in the capital area has continued to increase accounting for 45.3 percent of the total population in 1995.

In fact, population distribution policies, together with measurements, have been planned since 1962 when the economic development plan was launched. However, many policies and plans have not been successfully implemented. The continued increase in population concentration has brought negative impacts such as deepened disparity in development between regions, lack of infrastructure, rise in land price, deterioration of environment in the capital area, and so the Third National Plan for Land Development was implemented in 1992. Its goals include establishment of decentralized land form, an integrated communication network, improvement in living standards, introduction of the broad area-development system, choosing new industrial sites for development of the west coast, etc. Specifically, the broad area development system was aimed at developing 7 broad areas as a base for economic development, as substitutes to the capital area. The target population for each of the seven areas was set and the necessary input, including infrastructures were to be provided. The result of this plan is expected to effectively decentralize population and eventually achieve balanced development between areas.

2) International Migration

In Korea, the Emigration Act was promulgated in 1962, which recommended emigration mainly to accomodate the population policy and national economy. As a result, the number of emigrants increased, as shown in Table 9-5, to about 40 thousand in 1976.

However, the development of the national economy together with rise in income caused the number of emigrants to decrease and the number of return migrants to Korea to increase; the ratio of return migrants to emigrants was 2.8 percent in the 1980s, but increased to 60.7 percent in 1992. Despite the decreasing trend,

the ratio remained at over 50 percent until 1996. However, since the end of 1997 and the beginning of the economic crisis, the number of emigrants has increased and conversely the number of return migrants has decreased. The type of emigration is mainly emigration for employment and by invitation of relatives; the proportion of emigration for business and international marriage is relatively small.

Table 9-5 Trends in the Numbers of Emigrants and Return Migrants, 1962~June 1999

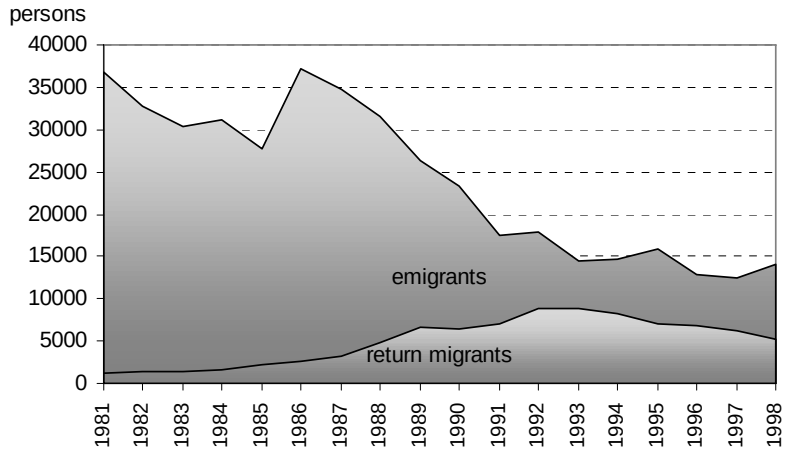
(Unit: persons, %)

Year	Emigrants (A)	Return Migrants (B)	(B)/(A) ×100(%)	Year	Emigrants (A)	Return Migrants (B)	(B)/(A) ×100(%)
1962	386	-	-	1981	36,805	1,189	3.2
1963	2,901	-	-	1982	32,809	1,346	4.1
1964	3,746	-	-	1983	30,382	1,426	4.7
1965	4,830	-	-	1984	31,111	1,669	5.4
1966	3,640	-	-	1985	27,793	2,290	8.2
1967	34,012	-	-	1986	37,097	2,584	7.0
1968	5,813	-	-	1987	34,798	3,301	9.5
1969	9,755	-	-	1988	31,486	4,734	15.0
1970	16,268	-	-	1989	26,272	6,685	25.4
1971	19,163	-	-	1990	23,314	6,449	27.7
1972	26,042	-	-	1991	17,433	7,029	40.3
1973	33,433	-	-	1992	17,927	8,892	49.6
1974	41,986	-	-	1993	14,477	8,781	60.7
1975	43,455	-	-	1994	14,604	8,236	56.4
1976	46,533	-	-	1995	15,927	7,057	44.3
1977	42,091	-	-	1996	12,929	6,824	52.8
1978	39,077	-	-	1997	12,484	6,262	50.2
1979	35,441	-	-	1998	13,974	5,190	37.1
1980	37,510	1,049	2.8	1999.6	7,051	2,452	34.8

Note: 1) The number of emigrants includes emigrants within the destination country and adoptees.
2) The number of return migrants includes permanent return migrants and those who give up emigration.

Source: Ministry of Foreign Affairs and Trade, *Unpublished Data*, 1999.

Figure 9-1. Trends in Emigrants and Return Migrants in Korea



There has been an increasing trend in the number of foreigners who have moved to Korea in the 1990s; this phenomenon is accounted for by the high growth of the Korean economy during the 1990s which has caused rise in wages and subsequently, level of income, so that laborers have developed the tendency to avoid difficult, dirty, and dangerous work. As a result, there has been lack of labor in medium manufacturer establishments. Foreign labor is inclined to work in Korea due to the high wages and also because medium manufacturing establishments prefer foreign workers who are not reluctant to be involved in hard and dangerous work for cheap wages. However, since the Immigration Law prohibits the migration of non-professional workers to Korea, the government has adopted a system of industrial training for foreigners as a means of mitigating the lack of labor, which allows a certain number of trainees and allots them to medium establishments suffering from lack of labor[13]. However, there

13) The annual number of trainees has been between 10 and 30 thousand

has been an increase in the number of illegal foreign workers moving to Korea.

Table 9-6 Trends in the Number of Foreign Laborers by Legal Status, 1994~1998

(Unit: persons, %)

Year	Total	Legal Workers	Trainees	Illegal Workers
1994	81,824(100.0)	5,265(6.4)	28,328(34.6)	48,231(58.9)
1996	210,494(100.0)	13,420(6.4)	68,020(32.3)	129,054(61.3)
1998	157,689(100.0)	11,143(7.1)	47,009(29.8)	99,537(63.1)

Source: Ministry of Labor, *Labor White Paper*, each year.

As can be seen from Table 9-6, the total number of foreign workers, legal and illegal, was estimated to be 81,824 in 1994 and 210,494 in 1996, showing an increase of 157.3 percent during two years; in 1996, approximately 61 percent of all foreign workers were illegally employed, in comparison to 58.9 percent in 1994. However, the economic crisis which began in 1997, has had an impact on the movement of foreign workers; the number of foreign workers working in Korea was 157,689 in 1998, which is a decrease of 25.1 percent, from 1996. The decrease may be due to the rise in the exchange rate and lack of jobs. However, the proportion of illegal foreign workers to total foreign workers is still high.

B. Future Policy Directions

In order to achieve a balanced spatial distribution of the population and other socio-economic development factors, the

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since 1992 and there are plans to have a total number of 93,800 foreign trainees by 1998. They have been alloted to manufacturers, construction, fishery, etc.(Ministry of Labor, 1999)

government should assess, on a regular basis, the consequences of economic and environmental policies, sectoral priorities, infrastructure investment and balance of resources among regions on population distribution and internal migration. When implementing the Third National Plan for Land Development, the government should, specifically, ensure that the objectives and goals are consistent with other development goals, policies and basic human rights.

The government should adopt sustainable regional development strategies; including adopting training for non-farm jobs for youths, effective transport and communication systems, continuous provision of incentives to encourage the redistribution and relocation of industries and businesses from urban to rural areas and to encourage the establishment of new businesses, industrial units and income-generating projects in rural areas, and establishment of the preconditions for development in rural areas, such as infrastructure, social services and facilities. The concentration of population into urban areas can be attributed, in great part, to the strong desire of Korean parents to educate their children in urban areas under a better educational environment and hence the investment in education in rural areas, in terms of personnel and facilities, will help keep in check the rural-to-urban migration and encourage return migration(Lee, 1991). Particular attention is needed to ensure that the return migrants and migrants' families remaining in rural areas are provided the support and assistance that will enable them to continue staying in rural areas. It should also take into consideration that policy to economically and socially support the elderly in rural areas would keep more population in rural areas, since they would have to, reluctantly, join their families in urban areas without the appropriate economic and social support(Lee, 1991).

The government should pursue development strategies that offer tangible benefits to investors in rural areas and to rural producers. The government should strengthen the capacity to

respond to pressures caused by high population concentration by revising and restructuring the agencies and mechanisms for urban management, as necessary, and ensure the wide participation of all population groups in planning and decision-making of local development. It should also consider further decentralizing administrative systems.

Chapter 10. NGO's Participation in Implementation of ICPD Goals

A. NGO's Roles for Achievement of ICPD Goals

The ICPD Programme of Action(UN, 1995) includes the provision of universal access to reproductive health services, including family planning and maternal and child health, adolescents' sexual health, the empowerment of women, gender equity and equality, and the welfare of the aged and families, etc,. Implementation of the Programme of Action requires a very broad range of activities including development and provision of programs. Thus, the Programme of Action calls for the promotion of an effective partnership between all ranges of government and the full range of non-governmental organizations and local community groups in the design, implementation, coordination, monitoring and evaluation of policies and programs.

The role that non-governmental organizations take has been increasingly important due to the reduction in government human and financial resources, the increased demand for reproductive health services, and the need for realization of human rights, including gender equality and equity. However, non-governmental organizations face an unfavorable environment, internally and externally. This includes lack of resources, internal capability, and partnership with the government and civil society. In particular, the recent economic crisis has resulted in reduction or termination of government financial support for non-governmental organizations.

The Republic of Korea has no compulsory central registration facility for non-governmental organizations. Instead,

non-governmental organizations normally register with the government authority dealing with its area of activities. Non-governmental organizations providing either services or medical functions register with the Ministry of Health and Welfare; those serving educational functions register with the Ministry of Education; those having a religious basis register with the Ministry of Culture and Tourism; those sponsoring research and development register with the Ministry of Science and Technology; and those claiming to represent the interests of civil society register with the Ministry of Home Affairs. Registration allows non-governmental organizations, as non-profit legal corporations, tax-exemption as well as opportunities for financial subsidies(ESCAP, 1997).

According to a recent report, the proportion of households where husbands are violent to wives was 5.6 percent[14]. The number of divorces is also increasing considerably. Although the participation of women in the labor force has shown a steady increase, there has been substantial sex discrimination in wages, opportunity for promotion, content of work, etc..

Sexual violence has also increased influenced both by the Western sexual culture and the weakening of morals. Thus, protection and empowerment of women have become a crucial social issue in Korea. Non-governmental organizations for women have played a crucial role in promoting gender equality and equity, which the government would have great difficulty achieving alone. The main functions performed by non-governmental organizations for women are presented in Table 10-1.

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14) A result from the Survey on Domestic Violence, Korea Institute for Health and Social Affairs, 1998.

Table 10-1. Main Functions Performed by Non-governmental Women's Organizations in Korea[1)]

Area	Role	Coverage
Protection	Temporary residential care; medical care; counseling; provision of services for rehabilitation to home, schools and jobs; transfer to Social Welfare Institutions	Women in need of care: victims of sexual violence and domestic violence, prostitutes, unwed mothers, etc.
Counselling	Problems with the opposite sex, marriage, divorce, family conflicts, pregnancy, sex, status of women, human rights, etc.	Women in general and in need of care
Program	Programs for prevention of sexual violence; fostering of proper sex culture; prevention of unethical behavior; domestic violence	Women in general and in need of care
Promotion of women's status	Performing a movement for promotion of gender equality and equity, and empowerment of women; encouraging of women's active participation in social activities and development of women's potential capabilities; pressure in legislation and policy	General population
Support for self-reliance	Establishing environment that fosters women's self-reliance; job education and vocational assistance	Low-income single-mother households, women in need of care, etc.
Public awareness	Awareness activities; provision of information	General population

Note: 1) These functions are derived from functions of non-governmental organizations dealing with women's affairs including counseling, welfare, protection, etc. such as YWCA, Korea Women's Hot Line, Sexual Violence Prevention & Care Center, Women's Association, Korea Sexual Violence Relief Center, Korea Women's Association United, Korea Women's Association for Democracy and Sisterhood, etc.

In close cooperation with women's non-governmental organizations, the Presidential Commission on Women's Affairs has put priority on policy regarding promotion of women's rights as an integral part of human rights. This policy priority extends to the creation of a society where gender-equal participation and the division of responsibilities in all political, social, economic and cultural fields are guaranteed. Women related laws have been enacted and amended to promote and extend further the rights of women and to support women with difficulties.

Non-governmental women's organizations have also been actively involved in legislation reform. The Punishment of Sexual Violence and Protection of Victims Act in 1994, the Domestic Violence Punishment Special Act, and the Prevention of Domestic Violence and Protection of Victim Act in 1997 were enacted to protect women from being victimized by domestic violence and sex-related crimes. In 1995, the Women's Development Act was enacted to protect maternity and to promote women's social participation. Recently in 1998, the Labor Standard Act was revised to prohibit work-out based sex discrimination, especially in relation to the recent financial crisis. The Prohibition of Gender-Discrimination Act was also enacted in 1999. The Equal Employment Opportunity Act, enacted in 1987, was amended in 1999 to include sexual harassment in the workplace.

To prevent the distortion in sex ratio at birth, the Korea Doctor's Association has performed a voluntary movement for stopping unethical behavioral such as the sex screening of fetus and sex selective induced abortions. Also, the PPFK conducts research and publicity in efforts to eradicate the son preference and to reduce the imbalance in sex ratio at birth. The effectiveness of non-governmental organizations' efforts resulted in amendment of the Medical Law in 1996. According to the law, a doctor that performs the sex screening of a fetus will have his/her license suspended.

In recent years, Korean society has witnessed serious adolescent sex-related problems; pre-marital conception, induced abortion, unwed mothers, sexually transmitted diseases and AIDS, etc., which all greatly threaten adolescents' reproductive health. To prevent adolescents' misled sex-related norms and behaviors, the home, school and society must each play an important role. However, no policies or programs are present that enabled the home(parents) to properly educate their children.

Sex education in schools started in the 1960's by providing basic knowledge on women's menstrual periods, on chastity in the 1970s, and on systematic knowledge and establishment of proper sex norms in the 1980s. However, effectiveness of sex education by schools has been doubtful, due to the absence of separate curriculum, expert teachers, etc,. Above all, discussions on sex between parents and children and between teachers and students is still perceived in Korea as inappropriate or awkward. In addition, some parents and teachers have a negative attitude towards sex education, afraid that sex education may encourage instead of prevent, adolescents' sexual activities. Furthermore, most parents and teachers have no professional knowledge due to the lack of sexual education.

Non-governmental organizations have advantages that home and schools do not have in dealing with adolescents' sexual problems with their professional knowledge and effective tools. Since the introduction of sex education by the PPFK, many non-governmental organizations such as YMCA, YWCA, Women's Welfare Centers, Counseling Center for Sexual Harassment, and Social Welfare Centers have provided sex education, counseling, personality tests, and other special programs to prevent adolescents' sexual behavior.

In particular, the PPFK offers sex education for school teachers, conducts research on teenager's sexuality, and develops papers on related issues. Table 10-2 presents the major activities of the PPFK in relation to adolescents' sex.

Table 10-2. Major Activities to Prevent Adolescents' Sex Related Problems by PPFK

Areas	Major Activities
Sex Education and Counseling	- Operation of counseling rooms and a sex counseling hotline for adolescents - Group sex education for adolescents - Sex education for middle and high school graduate classes - Cooperation with schools for sex education of adolescents - Sex education for university students/sex counseling training - Operation of programmes for adolescents
Training	- Training of adolescent leaders - Training of school teachers - Training of health related officials
Development & provision of materials	- Development of materials on sex education - Development of audio/video materials
Research for sex culture	- Operation of the Sex Culture Institute · Survey and research · Development of materials · Education and training

Source: PPFK, Cases of Adolescents' Activities, 1998

Since sexuality has traditionally been taboo in Korea, education and publicity of sexually transmitted diseases have become ineffective and counseling of the patient very difficult. Accordingly, it is necessary that education and information for prevention of sexually transmitted diseases and AIDS be continued. Also, the needed services including tests, counseling, condoms and medical care should be further accessible, affordable and available. The role of non-governmental organizations is very important for effective delivery service because of the negative social attitude on STD/AIDS.

Non-governmental women's and adolescents' organizations

actively function to prevent STD and AIDS. The non-governmental organizations established in 1993 with the increase in STD/AIDS include the Korean Federation for AIDS Affairs, the Korean Alliance to Defeat AIDS, the Institute for Movement to Stop AIDS, and Counseling for AIDS. PPFK is also involved in activities for preventing STD/AIDS. These non-governmental organizations perform awareness activities, provide education, counseling and information, AIDS tests, carry out surveys and research, train experts such as doctors and nurses, and protect human rights and welfare of AIDS patients and their family, etc..

The government faced the STD/AIDS situation by implementing the Epidemic Prevention Law and the HIV/AIDS Prevention Law in 1987, which stipulates duties of central and local governments and individuals, prevention of discrimination, protection of individual privacy, registration of HIV patients, compulsory tests, etc..

It is important to maintain systematic cooperation between local governments and community-based non-governmental organizations. The central government has supported local governments in the enhancing of partnerships with non-governmental organizations. For example, the Regional Health Law was enacted in 1995 to enable local governments to effectively establish cooperation with non-governmental organizations through securing of financial resources and supporting budget for local non-governmental organizations.

Research related non-governmental organizations collect data and perform research to provide the government with the basic data needed for establishment of policy and development of programs. These non-governmental organizations include the Korea Institute for Health and Social Affairs(KIHASA), the Korea Women Development Institute(KWDI), the Korea Education Development Institute, the Korea Adolescent Development Institute, etc. They are funded by the government[15],

hold international conferences, and perform research projects in collaboration with international organizations. The results are circulated to domestic and overseas policy-makers and program managers. These are also provided to the POPIN Center of each country through the Asia and Pacific POPIN Network and utilized as materials for international training in the TCDC program as part of South-South Cooperation.

The role of non-governmental sectors has become increasingly important, with the expansion of demand for reproductive health services, gender equity and equality, improvement of quality of life, etc. The government has made efforts to develop new programs and modify the previous programs in collaboration with non-governmental organizations and provided budget for non-governmental organizations to effectively carry out programs and provide a legal basis for their activities through legal reform. However, non-governmental organizations have faced various problems, within non-governmental organizations themselves and from changes in the environment. Among them are lack of financial resources, capability in the organizations, and professional manpower, etc..

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15) The government created a pseudo-NGO sector in the form of a number of semi-autonomous "institutes" ostensibly representing various civil society interests, established under government auspices and funded by government stipends, these government-organized NGOs(GONGO) represent the interests of their sponsors as much as their clients. These include KIHASA, dating back to the 1960s which is mandated with the task of promoting family planning within the context of the economic development plan, and the KWDI, established as an affiliate to the Ministry of Health and Welfare in 1983, to represent the women's movement within the parameters of acceptability set for it by the government(ESCAP, 1997). Currently, these NGOs are under the Office of the Prime Minister, which is a shift from the relevant ministries in order to promote independency in their activities.

B. Active Participation of Non-governmental Organizations

1) Lack of Financial Resources

NGOs' budget consists of membership fees, contributions, program profits, asset profits, government support, support from foreign cooperation and international organizations, and others. The majority of non-governmental organizations rely on membership fees and contributions, while a few non-governmental organizations are supported, although not fully, by the government[16]. The amount supported by the government is so small that government supported non-governmental organizations are not able to play an active role. Specifically, the recent economic crisis has led to reduction or suspension in budget support for non-governmental organizations.

For example, family planning was removed from the government's priority projects because of the high contraception rate and low fertility level. The government-supported budget was suspended in 1999, after reduction for many years. Family planning has not been acknowledged as a comprehensive approach to controlling population growth and to promoting reproductive health through prevention of adolescents' sexual problems, preventing STD/AIDS, promoting maternal and child health, etc.

Financial resources are important to secure professional and administrative manpower, offices, lecture rooms, counseling rooms, materials, etc,. As a voluntary association, a non-governmental organization needs to rely on self-support rather than external assistance in order to maintain its independence. To do so,

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16) According to the Law for the Protection of Private Fund Raising, NGOs' private fund-raising is prohibited. Therefore, the NGO sector, in general withered under growing financial constraints. Governmental financial support of NGO activities has continued to be provided through specific subsidies on a case-by-case basis.

expansion of members, systematic management of members, regular receiving of a small amount of membership fees, etc. are necessary. However, if a certain non-governmental organization has few members or has difficulty in managing its members within itself, government support is needed, directly and indirectly (for example, tax exemption).

In some cases, non-governmental organizations are involved only as a part of the government's project and there is no cooperation between government and non-governmental organizations. The number of non-governmental organizations is too large for the government to effectively support all of them with the limited budget. Cooperation between non-governmental organizations is often hindered due to over-competition and self-interest of non-governmental organizations. In order to effectively utilize the limited financial resources, networking and information exchange between non-governmental organizations needs to be established, but the effectiveness of cost and manpower to do this seems to be too low due to lack of cooperation between non-governmental organizations.

As a way of compensating for the deficiency or absence of government support, financial assistance from international organizations including the UN needs to be taken into consideration; however, although the decrease in financial resources of international organizations has resulted in reduction in support for non-governmental organizations, the non-governmental organizations lack systematic strategies by which they can compete with other non-governmental organizations to secure the support from those international organizations. It is also important for non-governmental organizations to promote cooperation between themselves in exchanging information and proposing projects.

2) Ineffectiveness in Organization and Operation of Non-governmental Organizations

Many non-governmental organizations do not have their own

programs, and they do not provide other related services; they focus mainly on provision of basic information, often being closed down after only a short period. Therefore, non-governmental organizations need to specify their main areas of projects as a form of program(i.e., awareness activities, education, counseling, etc.) and to secure professionals.

In general, a small non-governmental organization has many problems in its operation, including budget. Specifically, if it is not a nationwide organization, it becomes impossible to perform the programs and deliver the services needed in local areas. Large scale non-governmental organizations concentrate development mainly in central or local cities, resulting in regional non-governmental organizations needing support from other local branches or the central organization. Therefore, local non-governmental organizations are unable to develop the programs appropriate for its area, due to lack of budget and professional manpower.

In many cases, coverage of non-governmental organizations is limited, geographically and characteristically. For example, sex education by most non-governmental adolescents' organizations do not cover males and school teachers, due to budget shortages and the lack of a nationwide network and manpower. The related services and guidelines are not standardized and the service delivery system is ineffective. In many non-governmental organizations, its management is non-democratic and some professionals are involved in other work.

3) Need for Legal Support

Full provision of a legal basis that supports non-governmental organization activities is essential. For example, as yet there is no independent law for protection of adolescents from sexual violence, etc,. STD/AIDS related laws including the Epidemic Prevention Law are insufficient in inducing the social support and voluntary participation of patients.

According to the Labor Law industries with over 30 employees are required to have counseling offices to educate and provide counseling to young industry workers, but only a few industries have actually prepared them. Even when industries set up these counseling offices, the issues dealt with in the offices are mainly related to one's career path and vocational aptitude, not to sex-related issues. Although TV, movies, videos, internet, and publications are becoming increasingly sexually oriented, the related laws regulating penalty and punishment are still more or less ineffective.

4) Lack of Full Partnership

In order to overcome lack of financial resources and professional manpower, and thereby maximize the roles of non-governmental organizations, there must be full partnership between governmental departments, between central and local governments, between government and non-governmental organizations, and between non-governmental organizations themselves.

However, some areas in related government ministries are overlapping in distribution. For example, ministries dealing with adolescents' sexuality include the Ministry of Health and Welfare, the Ministry of Education, the Ministry of Labor, the Ministry of Administration and Autonomy, and the Ministry of Culture and Tourism. For this reason, it is difficult for non-governmental organizations to have a cooperative relationship with the government, or for non-governmental organizations themselves to have a cooperative relationship. Also, sex education material, related textbooks, and brochures are still not standardized(Lee, 1998).

It is difficult to maximize the synergy effect of non-governmental organizations due to lack of a systematic cooperative relationship. Lack of partnership between non-governmental organizations, due to over-competition, makes it difficult to effectively use the limited financial resources from the government. Along with the lack of

financial support from the government, the similar roles of the numerous non-governmental organizations make it difficult for the government to support them effectively. Also, competition for financial support from the government decreases the cooperation between non-governmental organizations.

Non-governmental organizations have not concentrated on readjusting and coordinating their roles to avoid overlapping. Duplication and inefficiency in the roles of governmental and non-governmental sectors exist and in some areas, the NGO-Government relationship may even be hostile or confrontational. No coordination organization has been established to restructure the roles and functions of governmental and non-governmental organizations. The regulations and/or guidelines needed to specify cooperation between the government and non-governmental organizations are also not there.

Above all, most important is the lack of awareness or understanding of the importance of the role of non-governmental organization's and partnership with the government.

C. Future Policy Directions

In order to establish partnerships between non-governmental organizations and the government and between non-governmental organizations themselves, namely vertically and horizontally, the organizational environment needs to be improved; this includes establishment of policy, promulgation of related laws, establishment of modalities to exchange opinions, development of common objectives and strategies, mutual agreement of each role, etc.

The government should encourage non-governmental organizations to actively participate in achieving goals and in order to achieve them must provide its rationalization and theoretical background. The government should adopt policy measures and guidelines and remove legal and bureaucratic obstacles so as to

facilitate the involvement of civil society organizations in policy discussions, health sector planning and the formulation, implementation, monitoring and evaluation of strategies and programs that achieve Programme of Action objectives.

The government and non-governmental organizations should work towards the enhancing and strengthening of cooperation and collaboration that foster an environment for partnership. In addition, the government and non-governmental organizations should develop systems for greater transparency so as to improve their accountability to their respective constituencies, as well as each other. Non-governmental organizations should strengthen the human resources and institutional capacity to develop and implement programs. Government should support non-governmental organization's efforts through adoption of new policies, legislative reform, and increase in financial and technical assistance. Specifically, the government should provide financial support for non-governmental organizations to implement integrated and comprehensive reproductive health programs.

Also, non-governmental organizations should put efforts, including seeking financial resources, towards becoming self-reliant, if not totally then at least partially. The distribution and overlap of functions of non-governmental organizations should be readjusted and strengthened so as to maximize utilization of limited human and financial resources. In order to construct a cooperative relationship among non-governmental organizations, a coordinating committee should be organized; this is expected to play a role in networking non-governmental organizations, exchanging information, and publicizing and implementing the goals in collaboration. In order to establish an environment that allows partnership between non-governmental organizations, principles or regulations that specify roles and collaboration of non-governmental organizations should be established.

One way of effectively utilizing limited resources is to develop an effective service delivery system. Also, development of

a monitoring system is required to evaluate the performance of non-governmental organizations and incentives should be given to non-governmental organizations that contribute the most to goal achievement. non-governmental organizations should work with research institutes in evaluating their performance and modifying the relevant programs on a regular basis. They should also strengthen networking with international societies through active participation in international forums.

NGOs need to increase cooperation with enterprises to take advantage of their management capacity, which can be one way of coping with shortages in human and financial resources. One example is social marketing programs; enterprises produce reproductive health services, the government provides subsidiaries and tax exemption, and non-governmental organizations deliver the services to users. Another example is provision of work environments by enterprises, and education and counseling to ensure safety of employees' reproductive health. non-governmental organizations can provide their professionality and experiences to enterprises in concerned areas.

Local governments should realize the importance of non-governmental organizations' roles. In order to facilitate non-governmental organization's roles, local governments should establish a cooperative relationship with non-governmental organizations and non-governmental organizations should develop and implement programs appropriate for the regions. The central government should support local governments so as to promote cooperation with community-based non-governmental organizations.

Non-governmental organizations should establish a cooperative relationship with the media, commercial sectors, religious bodies and leaders, community groups and leaders, etc. to achieve their goals. Non-governmental organizations and the National Assembly and parliamentarians should establish close relations; the National Assembly needs to recognize the importance of non-governmental organization's roles and provide needed support including legal

reform, approval of budget, reflection in policy, etc.; Non-governmental organizations should publicize their role and provide information to the National Assembly.

Non-governmental organizations also need to strengthen cooperation with international organizations such as the UN, UNESCO, UNFPA, UNICEF, WHO, World Bank, etc. for financial and technical support in collecting and analyzing data, advocacy, etc,. Non-governmental organizations should develop systematic strategies that secure support from international organizations.

Chapter 11. Summary and Conclusion

A. Population Change and Socio-economic Development

In Korea, the fertility rate has been maintained below the replacement level, attributed to the successful implementation of the National Family Planning program and socio-economic development including economic growth, rise in women's economic participation, urbanization, increase in educational attainment, reduction in infant mortality, etc. It is expected that the fertility decline will progress further in Korea with the increase in proportion of single women and attitude among women that it is necessary to decrease the number of children.

Improvement in nutrition, improvement in health status, change in life style, etc, which are often concomitant with socio-economic development, have played a role in reducing mortality, including infant and maternal mortality rates, thereby resulting in a considerable rise in life expectancy.

Decline in fertility and rise in life expectancy has resulted in decline in the population growth rate, which has been under 1.0% per annum during the 1990s and was officially projected to reach a zero population growth rate in 2028. As a result, the absolute size as well as the proportion of children to the total population will continue to decrease, the absolute size of the working age population will start decreasing after reaching its peak(36.5 million) in 2018, and the aged population 65 years of age or over will continue to increase with a high growth rate of approximately 4 percent per annum. The proportion of the elderly will reach 7 percent in 2000, indicating that Korea will become an ageing society. It will double in 2022, resulting in Korea becoming an aged society.

If the recent change in the total fertility rate is taken into consideration, the zero population growth rate can be expected to be reached in 2020 at a population size of 50.0 million, which is earlier than the official estimation, and population ageing will accelerate at an even higher speed, reaching 14 percent of the total population in 2021, one year earlier than officially estimated. Change from increase to decrease in labor supply will come 2 years sooner than the officially estimated year of 2018.

B. Reproductive Health

In Korea, the national family planning and maternal and child health programs have been a key element in reproductive health programs since 1962. As a result of a success in the national family planning program together with socio-economic development, Korea has experienced a drastic decline in fertility and mortality. However, the low fertility has resulted in an unbalanced sex ratio, an increase in the old population, and a high prevalence of selective abortions. In an effort to deal with these new problems, the government adopted a new population policy with emphasis on population quality and welfare in 1996.

The contraceptive practice rate increased to over 80 percent in 1997, although reproductive health services for those women in this unmet need group, who are in the low-income, low-level education category, need to be strengthened. With intensive efforts to improve maternal and child health, the percentage of women who have visited maternity hospitals or local health centers for pre-natal checkups has been constantly increasing to almost 100 percent and that of women with newborns increased to 81.0 percent in 1997. Also, most newborns were delivered in an institutional setting, due mainly to the expansion of the national medical insurance system, which has covered the whole population since 1989.

Since 1991, the government has included compulsory screening tests for high-risk mothers and/or couples in the Maternal and Child Health program to prevent congenital birth defects and protect maternal health through early detection; free tests treatment were provided for poor women since 1995 and all births have been free of charge since 1997. As a result, the rate of screening tests increased to 73.6 percent in 1997. All these efforts, together with a decline in the fertility rate, have played a role in reducing the maternal and infant mortality rates.

However, there are problems to be solved for further improvement of reproductive health; they include high prevalence in contraception for pregnancy termination, induced abortions, a low breastfeeding practice rate, increase in adolescents' sexual activities, increase in STD/HIV/AIDS, etc., which threatens the reproductive health of women.

To encourage breastfeeding, maternity hospitals and health centers should increase campaigns advertising the advantages of breastfeeding for maternal and child health. And the so-called "baby-friendly hospital initiative" must be enforced at maternity hospitals to improve the current low level of breast-feeding. Quality care services should also include the introduction of a neonatal intensive care unit at all maternity hospitals.

The number of induced abortions for ever-married women has considerably decreased. However, a number of abortions are concentrated into the younger age groups, which may be attributable to a lower family planning practice rate and higher proportion of unreliable contraceptive methods such as condoms and the rhythm method. More than one third of 1997 pregnancy outcomes were accounted for by pregnancy wastage, due mainly to induced abortions. Therefore special attention should be paid to this vulnerable group with effective measures in preventing induced abortions.

In Korea, adolescent sexuality has emerged as a serious social problem, with industrialization and family nuclearization. There

were 7,000 unwed mothers and the proportion of teenagers among unwed mothers has increased to 47.9 percent in 1997. As an effort to prevent adolescents' sexuality, sex education has been strengthened through schools and non-governmental organizations, and there has been legal reform against sexual abuse and violence. However, in schools, teachers instruct passive knowledge about sex on a biological level in a part of some subjects, not as independent subjects in the curriculum and only girls are taught sex education, which is limited to the theoretically biology of the physical structure.

The number of STD infected people in Korea are mostly concentrated into the younger age groups and the number of HIV positive patients continuously increased to reach over 1,000 by the end of September 1990. Most of them became infected through sexual intercourse and in the 20-30 year age group. Since the policy for managing AIDS was adopted in 1985, many efforts to curb the spread of HIV/AIDS have been made, including establishment of the AIDS Prevention Committee and AIDS Management Center, designation of AIDS as the second class communicable disease by the Infectious Diseases Prevention Act and promulgation of the AIDS Prevention Act, establishment of AIDS related non-governmental organizations, subsidies for treatment of AIDS, and AIDS surveillance through regular examination of vulnerable groups in public health centers, examination of donated blood, voluntary anonymous free examinations, etc.. However, mentioning sexual activities has been a strong social taboo in the Korean tradition, which has rended measures for preventing STD/HIV/AIDS ineffective.

For further efforts to improve reproductive health in Korea, program agencies pertinent to reproductive health should be organizationally and functionally integrated, by establishing a high level coordinating body consisting of representatives from concerned organizations. The government should increase the budget for RH services and expand their financial support for non-governmental organizations. Prevention of unwanted

pregnancies must always be given the highest priority and women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family-planning services should be offered promptly to avoid repeat abortions. For all these, the importance of family planning should not be underestimated, simply because demographic targets have been met.

Specifically for adolescents' sexual activities, special measures should be taken to make reproductive health services easily accessible to adolescents exposed to sexual health risks. Government should support integral sexual education and services for young people. Programs should involve and train all who are in a position to provide guidance to adolescents concerning responsible sexual and reproductive behaviour, particularly parents and families, and also communities, schools, mass media, etc,. Adolescents must be fully involved in the planning, implementation and evaluation of such information and services.

The goals of STD prevention and control minimize not only transmission, but also maintain population quality. Prevalence of STDs will be monitored through understanding of infection channels, prevention of transmission of infection, and through treating and managing of infected patients. Responsible sexual behaviour should be promoted and included in education and information programs. The needed services for the prevention and treatment of STD, examination, and counseling should be made widely available and affordable. The information and service delivery system must be built up through public health centers, linked to community level resources such as non-governmental organizations, the private sector, the media, schools, etc,. Legal and financial support to build the STD/HIV/AIDS prevention system should be expanded. Examination of AIDS, specifically anonymous examinations, should be provided to the general population. Above all, vulnerable groups should be encouraged to actively participate in controlling the AIDS pandemic.

C. Health, Morbidity and Mortality

The health of the Korean people has considerably improved and the resultant pattern of diseases has changed from acute communicable diseases to non-communicable chronic diseases. In efforts to improve the health of the people, the Government has increased high quality medical personnel and health and medical facilities, mainly through the expansion of the coverage of medical insurance scheme; progress in the medical system such as National Health Insurance program, the National Health Promotion program, and the New Population Policy; legal reform such as the Regional Health Law to promote health at the community; etc..

These efforts have resulted in reduction in mortality, specifically infant mortality rate and maternal mortality rate, and the resultant increase in life expectancy. However, the morbidity rate increased, implying that modern life style including drinking and smoking causes accidents, stress, and chronic diseases, and that rapid population ageing has resulted in predominance of noncommunicable chronic diseases. Specifically, the recent economic recession has had a direct impact on people's health, including increase in the number of undernourished children, in addiction to alcohol, drugs, etc, stopping receiving medical care or treatment, increase in mental illness, etc..

Special programs to further reduce mortality and morbidity should be designed to strengthen the change of dietary habits, smoking and drinking, increasing exercise, etc,. Specifically, early detection and treatment of cancer should be strengthened in primary health at the community level. Education and publicity relating to these should be provided on a continuous basis. The government should increase support and assistance, financially and technically, for the community to attain health improvement.

D. Gender Equality, Equity and Empowerment of Women

In Korea, the participation of women in the labor force has gradually increased and the proportion of women engaged in unpaid family work has decreased. In comparison with males, the proportion of females who have graduated high school or higher has gradually increased. The traditional gender roles for males and females are changing with the increase in women's participation in education and economic activities. There has been great efforts to improve women's status; Government has prioritized policy regarding the promotion of women´s rights and gender equality and equity, and integration of the formulation and implementation of women's policies into national development policies; the government has also put efforts towards the elimination of gender discrimination in employment and promotion through legal reform and increase in the proportion of women in governmental committees.

Recently, the policy has put emphasis on institutionalism, where welfare measures are expanded from the low income strata to women of all strata, such as expansion of daycare centers for children and for the elderly with dementia and the disabled, and protecting female victims from sexual violence. Specific programs were designed to support female headed households who face difficulty in managing their daily lives, through allowances to firms which employ female household heads and enactment of the Assistance of Women's Enterprise Act in 1999 for legal support. Legal reform for prohibition and prevention of sexual violence and harassment includes promulgation of the Punishment of Sexual Violence and Protection of Victim Act in 1994, the Domestic Violence Punishment Special Act, Prevention of Domestic Violence and Protection of Victim Act in 1997, and the Prohibition of Gender Discrimination Act in 1999.

However, women still face sexual discrimination in the labor market, including recruitment, wage, opportunities for promotion, working hours, job security, child care, and working conditions,

Specifically, the share of participation of husbands in housework and child-care is relatively small to wives. A gap in school enrollment rates still remains between the sexes, with female enrollment rates being lower at higher educational institutions. The son preference also, has resulted in an imbalance of the sex-ratio at birth.

Women themselves should make efforts to increase their self-esteem, change their consciousness and attitudes towards their positions, develop capability, etc, through education to promote women's status and attain gender equality. As the overburden from the dual-role responsibilities of women, both at home and the work place, negatively affect women's health, gender policy should include health and welfare services for women to promote maternity protection. The government should strengthen the implementation of laws, programs and policies, designed to eliminate the gender discrimination in the labor market. The government should increase compatibility of work with child-care, through flexible work-hours, extended maternity leave, introduction of family and child-care leave, extension of child-care services for children and integration of workplace child care into community based child-care.

In order to attain the balance in sex ratio, efforts against discrimination of women should be made. In the short run, the legal basis to punish the illegal fetal sex screening and sex selective induced abortion, including the Medical Law, should be reinforced; in the long run, education on gender equality and dignity of human life needs to be emphasized starting from primary school and at the same time, needs to be given to older parents who have a strong influence on young couples(Lee, 1998). These efforts, specifically education and publicity, should be continued, since son preference has long been rooted in Korean society. The enhancement of women's capability is urgently needed to meet the changing socio-economic environment of the 21st century.

E. Family Welfare

In Korea, nuclearization and/or family dissolution has become more and more prevalent, mainly due to fertility decline, migration, and increase in divorces. Women's participation in economic activities, has resulted in less time they can afford to housework and childcare. With the increase in divorce and sexual activity of adolescents, the number of children abandoned has increased. The weakening of the family's duty or filial piety in supporting their elderly parents has resulted in the increase in abandoned elderly. Specifically, the recent economic crisis has resulted in a rise in the number of impaired families, divorces and abandonment of homes by wives, domestic violence and child abuse, and a portion of homeless household heads.

Thus, the government has put efforts towards preventing family dissolution and protecting vulnerable people undergoing family dissolution. The efforts include support and assistance for those vulnerable families, the strengthening of protection and welfare for abandoned and abused people, and legal reform. In particular, the government has made efforts under the economic crisis, to reduce the unemployment rate through creation of jobs and establishment of a social safety net. For further efforts, the government needs to support and develop the appropriate mechanisms to assist families with children, dependent elderly and family members with disabilities, and support the viability of multi-generational families. Specifically, policies and plans should pay special attention to the vulnerable groups, including single-parent families including single-mother and single-father households, widows, abandoned children, and the elderly without economic support.

F. Population Ageing and Elderly Welfare

The number of elderly suffering from chronic diseases, dementia and who are bed-ridden, is increasing with rapid

population ageing in Korea. As a result, population ageing has increased the demand for welfare and medical care for the elderly. Efforts to improve health and welfare of the elderly, include legal reform, emphasizing productive welfare, and introducing of the old age pension system.

For further efforts, the increasing numbers and proportion of elderly people should be taken into consideration in all levels of government in mid- to long-term socio-economic planning. The government should seek to enhance the self-reliance of elderly people to facilitate their continued health. The necessary conditions should be developed to enable elderly people to lead self-determined, healthy and productive lives and to make full use of the skills and abilities they have acquired in their lives, for the benefit of society. The government should make efforts to secure the basic livelihood of the low-income elderly; this includes increasing the living costs paid to the poor elderly under livelihood protection to secure their minimum livelihood, expansion of the coverage of elderly people by the Old-age Pension, with increase in the amount of payment.

The roles and functions of public health centers should be strengthened with professional manpower support and equipment. Complex centers and counselling centers for the elderly with dementia should function to develop technology of prevention, diagnosis and treatment of dementia, to establish a local health information network for dementia patients, and to train nursers, medical doctors and counselors. Elderly welfare of people at home should be strengthened, through establishment and/or expansion of service centers for the elderly at home, home-helpers, daycare and short-term facilities, and Silver Line.

G. Population, Development and Environment

In Korea, rapid economic development, concomitant with industrialization and urbanization, and growing population have aggravated environmental deterioration and hence the Ministry of

Environment was newly established in 1980 in response to policies related to the environment. In 1996, the 「Environment Vision 21」 was set up and the Second Medium Complex Plan for Environment Improvement was established to implement the Vision 21. The volume-base garbage collection system was enacted throughout the country in 1995. Restricted use of disposal commodities has been reinforced from 1995, extending firms and commodities to be restricted. The legal reform has also been made. The government has promoted education and information, communication, and education of environment problems for public awareness.

However, environment policies in Korea have had the tendency to implement after-the-fact cures for the impact of demographic factors on the environment rather than prevention of environment degradation from the population. Consistent with the framework and priorities set forth in Agenda 21, the government needs to achieve population and environment integration. For this purpose, demographic factors should be integrated into environment impact assessments and other planning and decision-making processes aimed at achieving sustainable development. Policies must be implemented to address the ecological implications of the inevitable future increase in population and changes in concentration and distribution. Environment-friendly production and consumption should be reinforced.

H. Population Distribution

The continued rural to urban migration flows have resulted in excessively high concentration of population in large cities, specifically the capital area. Such a high imbalance in population distribution has had a serious socio-economic impact, both in urban and rural areas. Also, population concentration has expedited high concentration of manufacturers, finance and insurance establishments, public institutions and other social, economic, cultural and administrative facilities into the capital

area, which has led to unbalanced development.

Although population distribution policies have been planned since 1962 when the economic development plan was launched, not many policies and plans have been successfully implemented. In order to achieve a balanced spatial distribution of population and other socio-economic development components, the government should assess on a regular basis, the consequences of economic and environmental policies, sectoral priorities, infrastructure investment and balance of resources among regions on population distribution and internal migration. The government should adopt sustainable regional development strategies.

I. NGO Participation in Implementation of ICPD Goals

To successfully implement ICPD goals, all parties, including the government, non-governmental organizations, private sectors such as firms, and civil society should be encouraged to actively participate in establishing, implementing, monitoring, and evaluating related policies. Since the government alone cannot be responsible for all the efforts to achieve the goals, full partnership needs to be attained.

In order to establish partnership between non-governmental organizations and the government and between non-governmental organizations themselves, namely vertically and horizontally, the organizational environment needs to be improved; this includes establishment of policy, promulgation of related laws, establishment of modalities to exchange opinions, development of common objectives and strategies, mutual agreement of each role, etc. The government should support non-governmental organization's efforts through adoption of new policies, legislative reform, and increase in financial and technical assistance. Non-governmental organizations should put efforts towards becoming self-reliant. The distribution and overlap of functions of non-governmental

organizations should be readjusted and strengthened so as to maximize utilization of limited human and financial resources. In order to construct a cooperative relationship among non-governmental organizations, a coordinating committee should be organized. Principles or regulations that specify roles and collaboration of non-governmental organizations should be established in order to establish an environment that allows partnership between non-governmental organizations. In order to facilitate non-governmental organization's roles, non-governmental organizations should establish a cooperative relationship with the local governments, the National Assembly and parliamentarians, media, commercial sectors, religious bodies and leaders, community groups and leaders, etc..

Successful implementation of the ICPD Programme of Action is not aimed merely to meet international agreements but also, more importantly, upgrade policies in Korea, related to the improvement of quality of people's life in the forthcoming 21st century. In this context, the evaluation of achievements and identification of new challenges faced, and future policy directions in population and development, raised in this report, will be an important guideline in propelling the further implementation of the ICPD Programme of Action and new population policy, which stress improvement of the quality and welfare of Korean people, in the next century.

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