

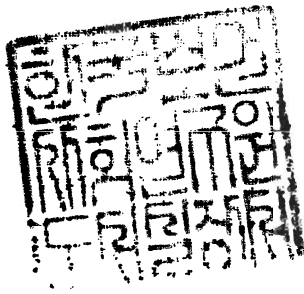
**AN OVERVIEW OF POPULATION
CONTROL POLICIES IN KOREA**

- A Summary Explanation -

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PREFACE

This publication has been prepared for those who are interested in Korea's population and family planning programs in an effort to promote their understanding of our national programs and to mutually share information on our experience in this field and on the problems we have encountered thus far.

This summary report consists of seven chapters. The first chapter is an overview of program policy developments in the chronological order, and following chapters are reviews of national program focusing on its past accomplishment and its prospects in the future as well as a few socio-cultural and demographic problems that we came across in the course of the program implementation. One of the major sources drawn upon in this report is the 1988 National Fertility and Family Health Survey conducted by Korea Institute for Health and Social Affairs (KIHASA).

The opinions and recommendations expressed in this report are those of the authors alone and do not necessarily represent the official position of KIHASA or the Korean Government. Finally, special appreciation is due to Nam-Hoon Cho, Director of Research Planning Division and Hyun-Oak Kim, Senior Researcher for their efforts in preparing this report.

June 1991

Dal-Hyun Chi, Ph.D.
President

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I. HIGHLIGHTS OF PROGRAM POLICY DEVELOPMENTS

The government of the Republic of Korea established an explicit population policy in 1961 and from the following year the establishment and operation of the national family planning program was included as a component of Five-Year Economic Development Plans since then. Most services have been provided through the family planning workers assigned to the government health networks and designated private physicians. This system has concentrated on the delivery of family planning services in rural areas. Because of explosive urbanization after 1962, however, the system in cities was no longer adequate to fill their growing needs, so urban family planning programs have been expanded since 1974. At the same time, social support policies to encourage small families as the norm have evolved. In 1981, the government devised the new innovative population policy measures emphasizing extensive social support policies. The following is a chronological overall view of program policy developments in Korea.

- 1961 – Adopted national FP program policy as a part of economic development plans starting 1962
 - Abrogated the law prohibiting importation and domestic production of contraceptives
 - Established Planned Parenthood Federation of Korea (PPFK) as a private voluntary organization
 - Adopted FP slogan “have few children and bring them up well”
- 1962 – Started national FP program under the jurisdiction of the Ministry of Health and Social Affairs (MOHSA) utilizing the government’s health delivery system
 - Established FP counselling room and assigned a FP worker at each of 183 health centers

- Introduced vasectomy, condom and jelly into the national program (The jelly was deleted from the program in 1963.)
 - Started training programs for FP workers, and for physicians on vasectomy procedure
- 1963 – Established MCH Division under the Bureau of Public Health, MOHSA
- Assigned two additional FP senior workers at each of 183 health centers
- 1964 – Assigned FP field worker at each of 1,473 township health sub-centers
- Started training program on IUD insertion for physicians
 - Introduced IUD into the national program
 - Used FP mobile teams to cover remote areas
- 1965 – Established FP Survey and Evaluation Team in MOHSA
- 1966 – Included FP target system in the national program
- 1968 – Organized FP Mothers' Clubs throughout country
- Introduced oral pill into the national program
- 1971 – Established Korean Institute for Family Planning (KIFP)
- Adopted FP slogan "stop at two regardless of sex"
- 1972 – Strengthened government program organization by establishing MCH Bureau in the MOHSA
- 1973 – Promulgated the MCH law legalizing induced abortion under certain conditions for medical reasons, and allowing para-medical IUD insertion
- 1974 – Initiated special urban FP projects
- Hospital project
 - Industrial site project
 - Urban low-income area project
 - Population education project
 - Home reserve army project
- Introduced MR service into the national program

- Income tax exemption up to three children
- 1975 – Started training program for physicians on female laparoscope sterilization procedures
 - Established Korean Association for Voluntary Sterilization (KAVS) as a voluntary organization
- 1976 – Introduced female sterilization into the national program
 - Established Population Policy Deliberation Committee (PPDC) under deputy prime minister
 - Assigned male information officer at each of 138 county health centers
- 1977 – Income tax exemption up to two children
 - Corporation tax exemption on expenditures for FP service to employees
 - Revision of family law on women's inheritance of property
 - Integration of FP Mothers' Clubs into Saemaul Women's Associations
- 1978 – Priority in allotting public housing to sterilization acceptors with two or fewer children
 - Tax exemption on contraceptive raw materials imported
 - Adopted FP slogan "a well bred girl surpasses ten boys"
- 1980 – Reduction of child delivery charges for sterilization acceptors after second delivery in public hospitals
- 1981 – Issued new innovative population policy to place great emphasis on social support policies and activation of FP program
 - Established Family Health Division in MOHSA as an integrated division of FP and MCH divisions
 - Upgraded health workers' status from temporary workers to regular health officials
 - Inaugurated Korea Institute for Population and Health (KIPH) as an integrated institution of KIFP and KHDI
- 1982 – Reorganization of FP section of provincial governments

making them Family Health Sections covering FP and MCH programs

- Provision of sterilization and IUD services through medical insurance system
- Priority to sterilization acceptors with two or fewer children for livelihood loans for the needy and housing loans
- Provision of monetary subsidies to low-income sterilization acceptors to compensate for lost wages (US\$140 for acceptors with two or fewer children, and \$40 for those with three or more children)
- Provision of primary medical services free of charge for 0-5 years old children of sterilization acceptors with two or fewer children
- Tax exemption on education allowance for first two children
- Family and education allowances for government employees with up to two children, in force from 1983
- Trial implementation of special projects
 - Monetary incentive system for sterilization acceptors with two or fewer children
 - New contraceptive method acceptance, cooper-T and foam tablet

1983 – Introduction of newly developed IUDs such as Copper T.

1985 – Expansion of medical insurance coverage to the married female workers' parents and the married workers' parents-in-law.

- Integration of individual FP, MCH, and TB workers into health workers in rural area.

1986 – Shifting contraceptive strategies from sterilization to reversible methods for the 20s age group.

1989 – Gradual changes in program management system to increase program quality and self-support contraceptive users.

1990 – Shift of policy directions from fertility reduction to population quality

II. PROGRAM ORGANIZATION AND OPERATION

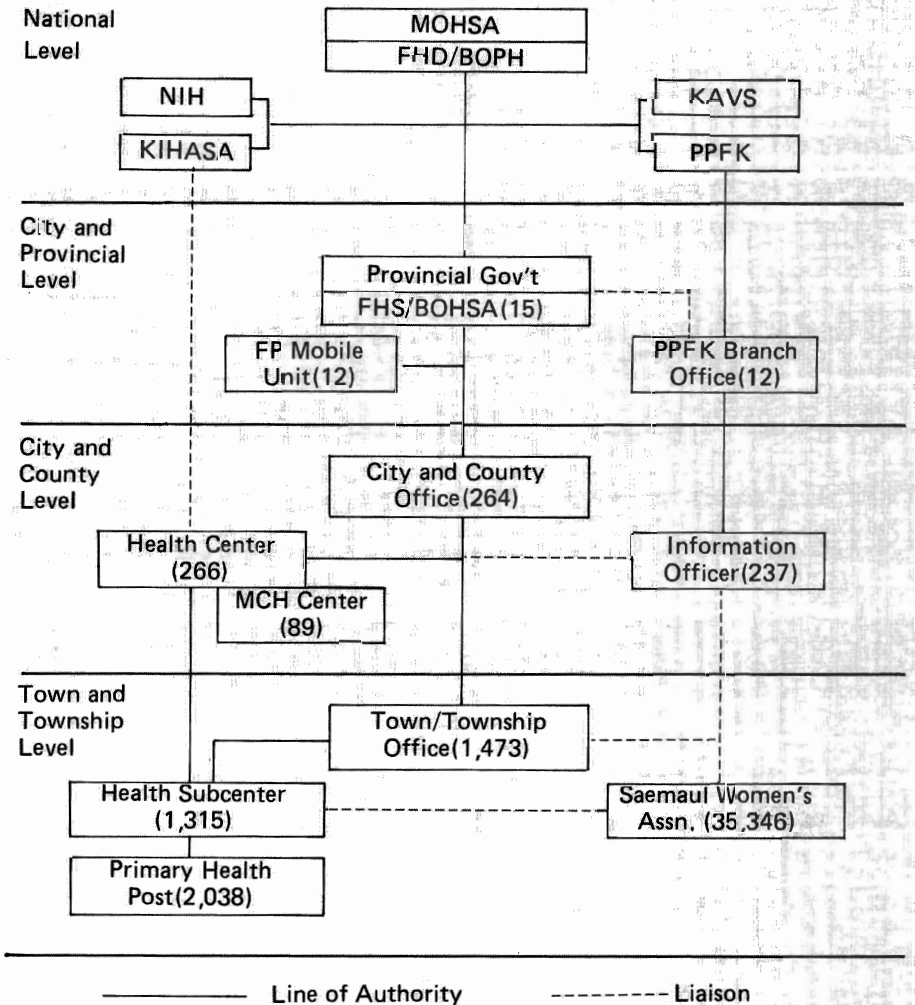
1. Program Organization

The Ministry of Health and Social Affairs (MOHSA) is responsible for the overall execution and implementation of the national family planning program. Within MOHSA, the Family Health Division in the Bureau of Public Health control all activities relating to family planning. At the provincial level, the Family Health Section in the Public Health Division is responsible for their overall control including the operation of the mobile unit. Health centers at the city and county level provide family planning services. The health centers are under the administrative control of the provincial government through city and county offices. At the township level, a field worker is assigned to each health sub-center to provide contraceptive services and motivation to the eligible population. Community health practitioners also work for the family planning program at the remote township level. The Saemaul Women's Association at the village level participates in the family planning program as a grass roots level volunteer organization.

The National Institute for Health (NIH) is responsible for program personnel training programs which were carried out by the Korean Institute for Family Planning(KIFP) till 1981. The Korea Institute for Population and Health (KIPH), a semi-governmental agency, was inaugurated in 1981 as an integrated institution of KIFP and KHDI and had responsibility for research and evaluation in the fields of population and health including family planning delegated to it. The name of the institute has been changed from the KIPH to the Korea Institute for Health and Social Affairs(KIHASA) as of 1 January 1990, following the enlargement of its functions to include social welfare research in addition to the existing population and health research. The Planned Parenthood Federation of Korea (PPFK), a private voluntary association established in 1961, has responsibility for the IE&C support component of the national program, including support for the Saemaul's Women's Association's nationwide system. The Korean Association for Voluntary Sterilization (KAVS), a private voluntary organization established in 1975, is responsible for physicians' training courses, and maintenance of

the sterilization equipment provided by the government. This arrangement enables the delegation of responsibility to the participating agencies, thus taking advantage of their particular strengths of each and minimizing duplication while maintaining program integration.

Program's Organization Network



2. Program Operation

Most contraceptive services are provided through family health workers and designated private physicians. The health workers distribute condoms and oral pills themselves, and refer sterilization and IUD acceptors to the designated physicians. In 1962, the government began to allot nurses and mid-wives as family planning workers to the individual health centers. Gradually, family planning workers were allocated to health sub-centers in township areas. Starting in 1967, health centers and health sub-centers were staffed with a maternal and child health(MCH) worker and a tuberculosis(TB) worker. In 1981, the status of the above three workers was upgraded from temporary position to a permanent government health official. In 1985, the government took an action to merge the three types of health workers(FP, MCH, and TB) into integrated health workers. The total number of health workers in 1990 is 5,337. The ratio of worker to target women aged 15-44 averages one worker per 1,300 women in rural areas, and one for every 6,200 in urban areas.

There is currently a total 2,976 family planning designated hospitals and clinics throughout the country. The designated private physicians, who have been trained and approved by the government, provide contraceptive services at their own clinics and are reimbursed by the government on a per case basis. IUDs and sterilization services are provided free of charge. Also, the government since 1974 has provided MR services only to low-income women unwantedly pregnant due to contraceptive failure. IUDs, condoms, and oral pills are distributed for a very modest services fees.

Health Workers and Authorized Clinics

Types of Personnel	Number of Persons/Clinics
Regular Government Health Workers	5,337
Urban : 1,520	
Rural : 3,817	
FP Designated Clinics	2,976

III. PROGRAM ACHIEVEMENTS AND CONTRACEPTIVE USE

1. Program Achievements

From 1962 to 1991, more than 17.8 million people received contraceptive services under the national program. The IUD was the principal method used from the beginning of the program until 1976. But since the female sterilization program was introduced in 1976, there has been a sharp increase in the number of female sterilizations while the use of IUDs, oral pills, and condoms has declined.

After an innovative population policy was adopted in December 1981, the high acceptance rates of all methods except oral pill has been maintained. However, the number of new acceptors in recent years fell steadily due to the lower target set for all methods since the fertility in Korea reached below replacement level in 1987.

Contraceptive Acceptors by Government Programme, 1962-91

Unit: Thousand(%)

Year	IUD	Sterilization	Condom	Oral Pill	Total
1962-66	725.6 (47.9)	82.3 (5.5)	706.1 (46.6)	—	1,514.0 (100.0)
1967-71	1,460.8 (52.3)	87.1 (3.1)	759.8 (27.7)	487.7 (17.4)	2,795.4 (100.0)
1972-76	1,619.2 (42.3)	219.5 (5.7)	859.1 (22.4)	1,134.2 (29.6)	3,832.0 (100.0)
1977-81	1,067.0 (33.2)	1,089.9 (33.9)	447.5 (13.9)	612.2 (19.0)	3,216.6 (100.0)
1982-86	1,017.9 (27.6)	1,732.6 (47.0)	591.8 (16.1)	344.4 (9.3)	3,686.7 (100.0)
1987-91 *	1,066.9 (39.5)	886.9 (32.8)	624.5 (23.1)	125.3 (4.6)	2,703.6 (100.0)
Total(62-91)	6,957.4 (39.2)	4,098.3 (23.1)	3,988.8 (22.5)	2,703.8 (16.2)	17,748.3 (100.0)

* 1991 Programme Target

Source: Family Health Division, MOHSA,
Family Planning Monthly Reports, 1962-91.

2. Family Planning Slogans

Family planning slogan have been changed in accordance with changes in the fertility level. The first slogan for the early 1960s when the nation's fertility was quite high, was "Have few children and bring them up well".

In 1971, a slogan reflecting growing concern over son preference and emphasizing having two children was introduced. This was "Stop at two regardless of sex". Along with the fertility decline in 1984, slogans emphasizing the advantages of having one child were introduced such as "Even two are too many", and "Have one child with happiness and love".

Changes in Family Planning Slogans

Year	TFR	FP Slogan
1961	6.0	Have few children and bring them up well.
1971	4.7	Stop at two regardless of sex.
1978	2.7	A well bred girl surpasses ten boys.
1984	2.1	Even two are too many.

3. Contraceptive Acceptors' Characteristics

The age of women acceptors of IUD and sterilization services through the government program fell sharply from 31.5 in 1980 to 28.9 in 1990, and their number of children went down from 2.9 to 1.7 during the same period. These demographic changes of contraceptive acceptors have been attributed mainly to several program managerial factors such as program evaluation systems with emphasis on sterilization acceptors with two or fewer children, award systems for outstanding performance organizations and personnel based on evaluation results, and high aspiration and attention of program managers at all levels on the program evaluation system.

Age and Number of Children at Time Contraceptive Acceptance: 1980–1990

Method	No. of Children		Age of Women	
	1980	1990	1980	1990
IUD	2.7	1.6	30.6	28.2
Vasectomy	2.6	1.9	31.3	29.6
Tubectomy	3.2	2.1	32.5	29.9
Total	2.9	1.7	31.5	28.9

Source: KIHASA, 1990 National FP Program Evaluation Report, 1990.

4. Changes in Contraceptive Practice

Thanks to strong population control policies, the contraceptive practice rate for eligible married women aged 15-44 increased from 9 percent in 1964 to 77 percent in 1988. The rapid increase in contraceptive practice rate since 1982 was attributed to the strengthened population control policy measures adopted in December 1981.

**Family Planning Status of Married Women Aged 15-44
1964-1988**

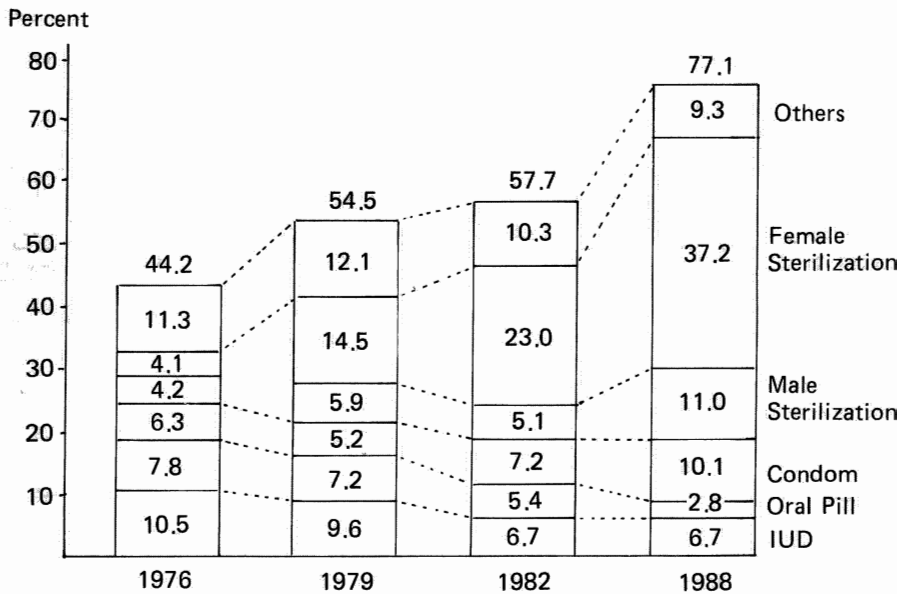
(Unit: %)

Status	1964	1979	1982	1985	1988
Current users	9	55	58	70.4	77.1
Past users	3	21	23	13.3	11.4
Never used	88	24	19	16.3	11.5
Total	100	100	100	100	100

Source: KIPH, National Fertility and Family Health Survey Data

When the contraceptive practice rates are compared by method, the sterilization practice rate increased drastically from 20.4 percent in 1979 to 48.2 percent in 1988, while the practice rates for reversible methods did not change much during the same period. This is attributed to the government's strategy on contraceptive distribution with emphasis on sterilization since 1976.

Contraceptive Practice Rate by Methods



Source: KIPH, National Fertility and Family Health Survey Data

The practice rate also varied by age of women and by number of their children. As shown, the practice rate increased for all age groups. The highest contraceptive use occurred in the 35-39 age group (89.6%) and among those with three children (90.5%). In the future, more efforts should be given to women in their 20s or with lower parity. This implies temporary contraceptive methods are increasingly important.

**Contraceptive Practice Rate by Women's Age
and Number of Children**

(Unit: %)

Characteristics	1992	1985	1988
By Age Group			
15 – 24	22.5	35.8	44.4
25 – 29	44.6	60.8	65.4
30 – 34	71.7	84.2	86.8
35 – 39	79.9	87.2	89.6
40 – 44	62.3	69.6	81.6
By Number of Children			
0	11.0	13.8	21.0
1	24.3	44.7	58.1
2	66.7	82.5	89.3
3	76.4	84.5	90.5
4	70.8	80.1	87.6
5 or more	64.2	76.3	83.8
Total CPR	57.7	70.4	77.1

Source: KIPH, National Fertility and Family Health Survey Data

Of the total 77.1 percent, 46.8 percent are currently practicing contraception under the government program, while 27.8 percent are under the self-supported program. However, large proportion of self-support users use ineffective method.

Contraceptive Practice Rate by Source of Support, 1988

(Unit: %)

Method	Gov't Sector	Private Sector	Medical Insurance	Unknown	Total
Oral Pill	0.3	2.5	-	-	2.8
Condom	1.3	8.8	-	-	10.1
IUD	3.9	2.4	0.2	0.2	6.7
Tubectomy	31.7	4.2	0.8	0.5	37.2
Vasectomy	9.6	0.6	0.1	0.7	11.0
Others	-	9.3	-	-	9.3
Total	46.8 (60.7)	27.8 (36.1)	1.1 (1.4)	1.4 (1.8)	77.1 (100.0)

Source: KIPH, National Fertility and Family Health Survey Data

5. Induced Abortion Trends

In spite of legal, social, and ethical constraints, as well as extensive contraceptive services offered by the government, induced abortion among married women aged 15-44 increased yearly in the 1960s and 1970s. According to KIPH survey findings however, it has slowed in the 1980s. The total abortion rate of married women increased more than four times from 0.7 in 1963 to 2.9 in 1978, but it fell to 1.6 in 1987. However, abortion rates of women in their 20s show an increasing trend. More attention should be given to these women.

**Trends in Induced Abortion Rates
for Currently Married Women, 1963-1987**

Age	1963	1973	1978	1981	1984	1987
20 – 24	16	86	70	74	91	108
25 – 29	29	75	156	158	146	107
30 – 34	58	137	148	146	115	72
35 – 39	40	88	156	106	40	28
40 – 44	—	22	54	48	20	7
T.A.R.	0.7	2.1	2.9	2.7	2.1	1.6

Source: KIPH, National Fertility and Family Health Survey Data

6. Changes in Institutional Delivery & Infant Mortality

One of the factors that have contributed to the reduction in fertility rate and the increase in contraceptive practice rate is the improvement in MCH. According to the national survey conducted by KIPH, the institutional delivery rate increased from 75.2 percent in 1985 to 87.9 percent in 1988.

Changes in Institutional Delivery Rates

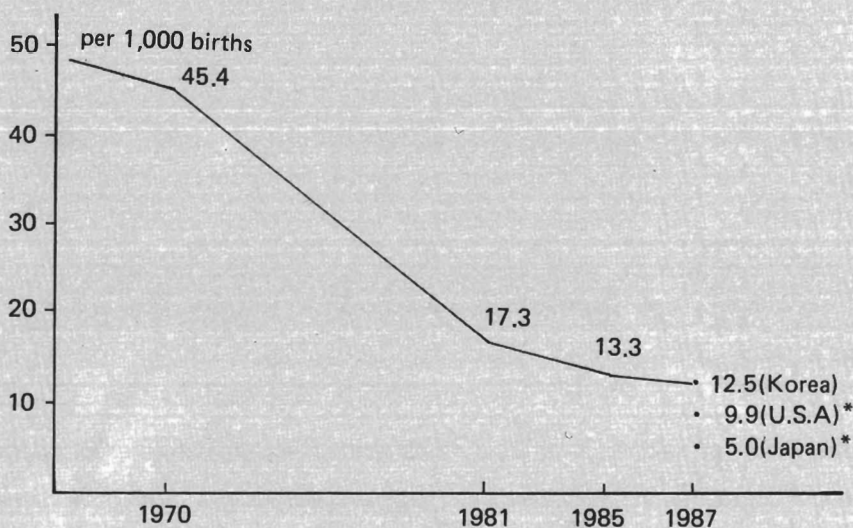
(Unit: %)

Place of Delivery	1985			1988		
	Urban	Rural	Total	Urban	Rural	Total
Institutional	84.4	50.9	75.2	92.9	73.3	87.9
Home	15.6	48.7	24.7	7.0	26.6	12.0
Others	0.0	0.4	0.1	0.1	0.1	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: KIPH, National Fertility and Family Health Survey Data

In inverse proportion to the level of the socio-economic and health developments in Korea, the infant mortality rate fell sharply from 45.4 per thousand births in 1970 to 12.5 in 1987. The reduction of IMR has contributed to the reduction of the fertility rate through the formation of small family norm.

Trends in Infant Mortality Rates



Source: National Statistical Office, Recent Changes in Vital Statistics and New Population Projections, 1989

*UN. Demographic Yearbook, 1988.

IV. CHANGES IN FERTILITY AND VITAL RATES

The total fertility rate had declined by 73 percent from 6.0 to 1.6 between 1960 and 1987. The rate of decline applied to all age categories. The decline for those in their twenties is mainly due to a rise in the age at marriage, while for those between 30-34, the 85 percent decline was mainly due to contraceptive use and induced abortion. The change in fertility level for those in the 25-29 age category has been relatively slow, 49 percent decline during the same period. A study shows that in 1970, the rise in the age at first marriage accounted for 38.6 percent reduction in fertility, while induced abortion contributed 29.4 percent, and contraception 31.9 percent but in 1985 survey, induced abortion for 32.2 percent and contraception 50.3 percent in the fertility reduction. Basically, socio-economic developments have contributed to the fertility decline by changing attitudes toward the small family norm and family planning. But the gap between fertility in urban and rural areas still remains large; a national sample survey in 1988 showed that the total fertility rate in urban areas was 1.52 but 1.96 in rural areas.

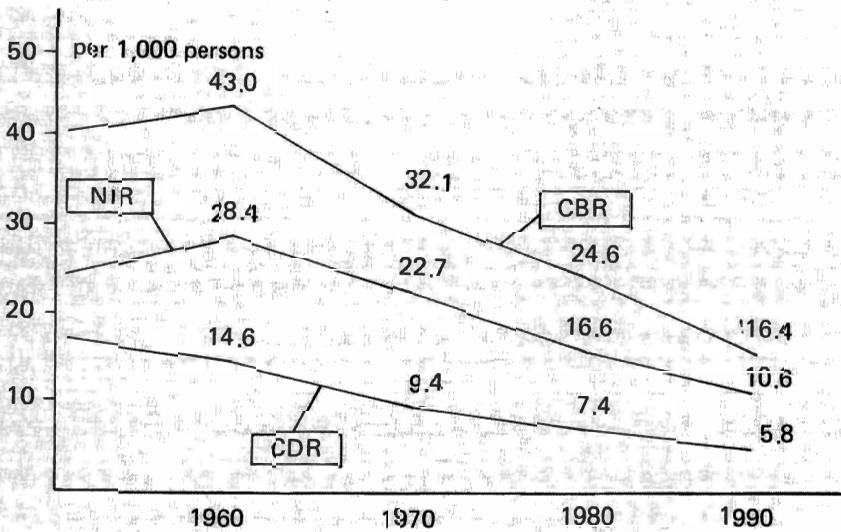
Changes in Age Specific Fertility Rates, 1960-1987

Age	1960	1971	1976	1982	1984	1987
15-19	37	6	10	12	7	3
20-24	283	188	147	161	162	104
25-29	330	341	275	245	187	168
30-34	257	234	142	94	52	39
35-39	196	120	49	23	8	6
40-44	80	41	18	3	1	3
45-49	14	3	1	—	—	—
TFR	6.0	4.7	3.2	2.7	2.1	1.6

Source: KIPH, 1988 National Fertility and Family Health Survey Report, 1989.

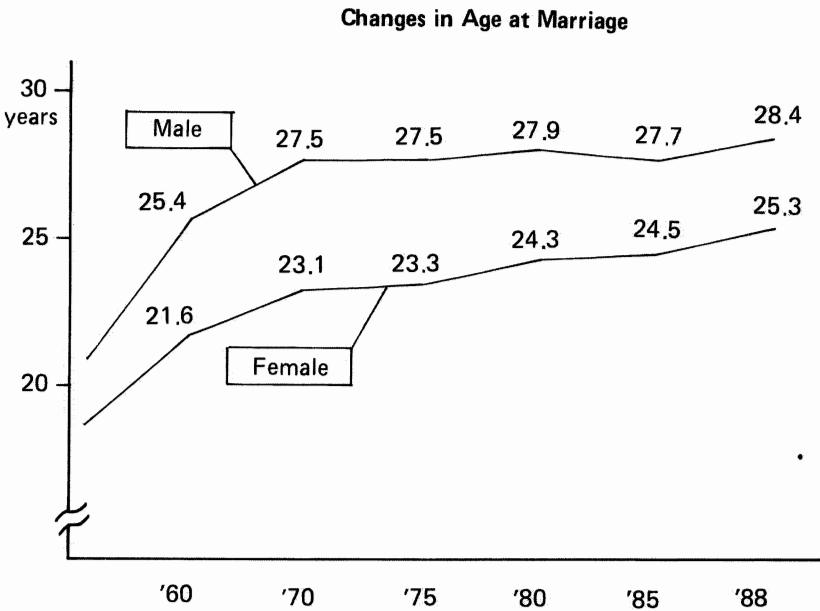
The crude birth rate declined from 43.0 in 1960 to 16.4 in 1988 and the crude death rate from 14.6 to 5.8 per thousand people during the same period, which means that the natural increase rate has declined from 2.84 to 1.06 percent per annum in the last 28 years.

Changes in Vital Rates, 1960-1990



Source: National Statistical Office, Population Census Data (1960-1990) and New Population Projection (1985-2021), 1991

The fertility decline in the past years has been partly attributed to the rising age at marriage. The mean age at marriage for women rose from 21.6 in 1960 to 25.3 in 1988, while the age for men increased from 25.4 to 28.4 during the same period.



Source: NBOS/EPB, Recent Changes in Vital Statistics and New Population Projections, 1989

V. POPULATION PROSPECTS

1. Population Growth

In 1991, new population projections for drawing up the seventh Five-Year Economic and Social Development Plan(1992-96) were made assuming that the total fertility rate will maintain at the current level of 1.7 in the coming years.

Based on the 1990 population census, the 1990 population of 42.9 million is expected to increase by 9.1 percent and reach 46.8 million by 2000, and the population will stabilize at around 50.6 million by the year 2021.

As Korea has achieved its demographic transition with a low mortality rate and a below replacement fertility level, it should change its role to accommodate recent population policy and program changes as well as design and develop future population policy and program directions in accordance with its emerging socio-economic and demographic condition.

New Population Projections

Year	Population (000)	CBR (0/00)	CDR (0/00)	CMR (0/00)	PGR (0/00)
1990	42,869	15.6	5.8	0.5	0.93
1991	43,268	15.5	5.8	0.5	0.92
1995	44,851	15.2	5.9	0.4	0.89
2000	46,789	14.2	6.1	0.4	0.79
2010	49,683	11.3	7.2	0.4	0.37
2021	50,586	10.0	9.7	0.4	0.00

Source: National Statistical Office, New Population Projection(1985-2021), 1991. 4

2. Population Structure

Due to the continuing decline in fertility, the proportion of population aged less than 14 decreased from 42.3 percent in 1960 to 25.8 percent in 1990, and will decline continuously to 21.2 percent in the year 2000, while the population aged 65 or more will increase from 5.0 percent in 1990 to 6.8 percent in the year 2000. Accordingly, the dependency ratio of 86 in 1960 declined to 44 in 1990 and will gradually decline to 40 in the year 2000. If the trend continues, Korea will soon face population aging problems.

Changes in Population Structure; 1960–2001

Year	Total Pop.	Age Composition (%)				Dependency Ratio(%)
		0-14	15-64	65+	Total	
1960	25,012	42.3	54.8	2.9	100.0	82.6
1985	40,806	30.1	65.6	4.3	100.0	52.5
1990	42,869	25.8	69.2	5.0	100.0	44.5
2000	46,789	21.2	72.0	6.8	100.0	38.8
2010	49,683	19.1	71.5	9.4	100.0	39.9
2021	50,586	15.8	71.1	13.1	100.0	40.6

Source: NSO, Results of 1990 Population Census and New Population Projections, 1991.

VI. STRENGTHS & WEAKNESS OF THE PROGRAM

1. Strengths of the Program

Examining the factors contributed to the reduction of fertility rate in Korea, it was largely attributed to the vigorous implementation of national family planning programs, rise in age at marriage, wide spread use of induced abortion, and changing attitude and norms toward smaller family based on the rapid socio-economic development. In addition, the success of the national family planning program has been attributed to the following advantages: 1) a pluralistic system of program management with active participation of various government and private organizations, 2) utilization of a large corps of FP workers for interpersonal communication and education and private physicians for providing contraceptive services, 3) a systematic program management system including program planning of target setting and allocation, program evaluation, and supervision, 4) numerous social support policy measures including incentive and disincentive schemes, and 5) strong political commitment by the government to the program.

Strengths of The Korean FP Program

1. A pluralistic system of program management with active participation of various government and private organizations.
2. Utilization of a large corps of FP workers and private physicians.
3. A systematic program management system including program planning (target), evaluation, and supervision.
4. Numerous social support policy measures including incentive and disincentive schemes.
5. Strong political commitments to the FP program.

2. Weakness of the Program

In spite of the success of the national family planning program in Korea, there have been a number of weaknesses in program quality and use effectiveness.

First, the IUD and oral pill discontinuation rates have been unusually high. For example, the discontinuation rate for IUD for twelve months of use has maintained about 47 percent during 1976 through 1985, while the discontinuation rate for oral pill for twelve months of use increased from 66 percent in 1976 to 72 percent in 1985.

This high discontinuation rates may be attributed to the shift from temporary method to sterilization and abortion and the other factors such as side effects of temporary methods and inadequate follow-up services for the acceptors.

High Discontinuation Rates of Contraceptives*

Ordinal Month of Use	IUD		Oral Pill	
	1976	1985	1976	1985
1	18.2	12.8	30.4	23.0
3	27.4	24.6	44.7	45.8
6	36.4	34.2	53.5	59.9
9	40.8	39.0	58.7	65.5
12	47.3	46.0	65.6	71.8

*Cumulative termination rates.

Source: KIPH, Fertility Changes in Korea, 1987

Second, most contraceptive users in Korea practice family planning to terminate fertility rather than to space children. This results in delayed contraception and unnecessary fertility. According to 1988 survey data, 91 percent of the contraceptive users practiced contraception to terminate fertility.

**High Proportion of Contraceptive Uses
for Fertility Termination**

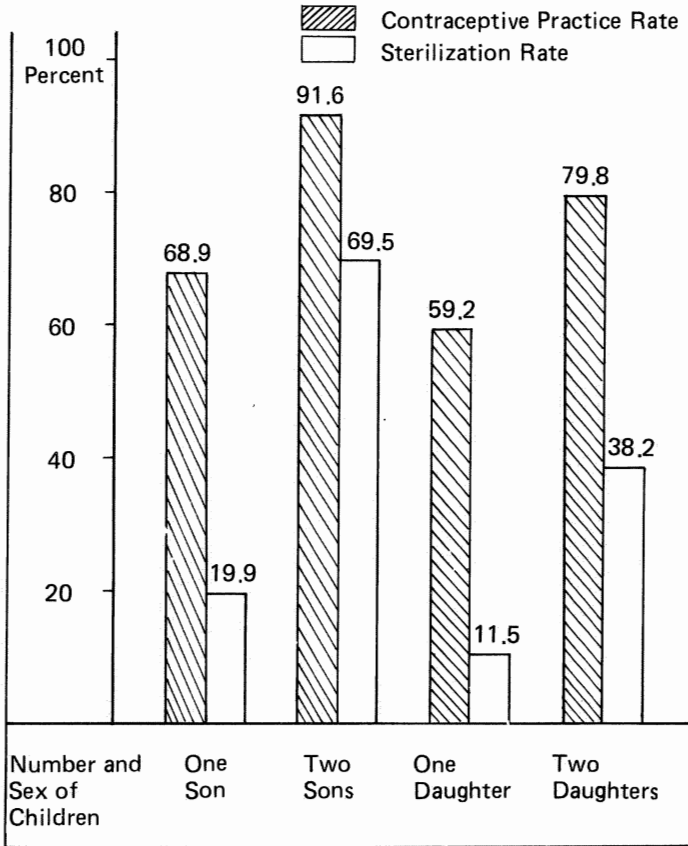
(Unit: %)

Purpose of Contraceptive Use	1978	1985	1988
Fertility Termination	91.9	90.8	90.7
Spacing	6.2	5.7	7.4
Others	1.9	3.5	1.9
Total	100.0	100.0	100.0

Source: KIPH, National Fertility and Family Health Survey Data

Third, son preference in Korea exerts a substantial influence on family planning practice. According to KIPH 1988 survey findings, 91.6 percent of couples with two sons and 68.9 percent of those with one son are practicing contraception. However 79.8 percent of those with two daughters and only 59.2 percent of those with one daughter are practicing contraception.

**Contraceptive Practice Rate
by Number and Sex of Children, 1988***



*Those who are currently pregnant couples are excluded.

Source: KIPH, National Fertility and Family Health Survey Data

According to the vital registration data, the sex ratio of third birth increased from 109.3 in 1982 to 170.5 in 1988, and a similar trend is observed among the fourth or above births; 114.2 vs 199.1 in 1982 and 1988. This is attributed to the fact that those parents with no male heir are willing to go on to the next higher parity, and sex selection procedures were used by a large number of parents. This trend may stop with the revision of the medical law in 1986 in which the identification of the fetal sex is strictly forbidden except in limited conditions.

Trends of Sex Ratio by Birth Order

Birth Order	1982	1984	1986	1988
First	105.5	106.4	107.6	107.2
Second	106.1	107.5	111.7	113.5
Third	109.3	118.5	141.4	170.5
Fourth or Above	114.2	131.7	157.4	199.1
Total	106.9	108.7	112.3	113.6

Source: NBOS/EPB, Recent Changes in Vital Statistics and New Population Projection, 1989

VII. FUTURE PROGRAM DIRECTIONS

In order to overcome these weaknesses mentioned, the following areas must be considered. First, the current program management and operation system must be improved for enhancing program quality. Specifically the new contraceptive acceptors in their 20s or with low parity must be recruited for birth spacing and offered more choice of contraceptive method. The management skills including program planning, monitoring and supervision for the local program managers at all levels should be strengthened. And the distribution of contraceptive services must be gradually shifted from the government supported program to the self-supporting programs.

Improve the Current Program Management and Operation System for Enhancing the Program Quality

- o To recruit the new contraceptive acceptors in their 20s or with low parity for birth spacing, and offer more choice of contraceptive methods.
- o To strengthen the management skills including program planning, monitoring and supervision for the local program managers at all levels.
- o To gradually shift the distribution of contraceptive services from the government supported programs to the self-supporting programs.

Second, family planning program must be integrated with health and other development programs, which include the primary health care, MCH, medical insurance, and other community development programs.

And specific management schemes for the integrated approach should be developed, which includes standardization of record and reporting forms, development of manual and training program for health workers, and organizational and functional set-up for the integration, etc.

Integration of FP Program with Other Development Programs

- To strengthen integration of FP with other health programs
 - Primary Health Care
 - Maternal and Child Health
 - Medical insurance
 - Other community development programs
- To develop the management scheme for the integrated approach
 - Standardization of record and reporting forms
 - Development of manual and training program for the integrated health workers, etc.

Lastly, social support policies to maintain a balanced sex ratio must be strengthened. That is, 1) developing policy measures to improve women's status and equality of the sexes, 2) developing social security benefits for support of old-age parents, and 3) strengthening population, FP and reproductive health education for unmarried persons and in and out of school youth.

Strengthening Social and Institutional Support Policies

- To develop innovative social support policy measures to improve women's social status and equality of the sexes.
- To develop social security benefits for support of old-age parents.
- To strengthen population, FP and reproductive health education for unmarried persons and in and out of school youth.

Appendix: Government Contraceptive Services by Year, 1962–1990

(Unit: thousand)

Year	IUD	Vasectomy	Tubectomy	Condom*	Oral Pill*
1962	—	3.4	—	59.4	—
1963	1.5	19.9	—	129.8	—
1964	106.4	26.3	—	156.3	—
1965	226.0	12.8	—	191.7	—
1966	391.7	19.9	—	168.9	—
1967	323.4	19.7	—	152.7	—
1968	263.1	16.0	—	135.2	26.3
1969	285.5	15.5	—	147.7	91.2
1970	295.1	17.3	—	163.0	170.5
1971	233.7	18.6	—	161.2	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	5.4	172.7	242.0
1975	343.9	43.0	14.5	196.7	240.1
1976	297.9	44.9	35.5	158.1	203.4
1977	281.8	53.8	181.4	103.2	178.9
1978	240.9	36.9	193.4	110.9	130.5
1979	188.7	25.9	195.3	80.7	108.7
1980	188.4	28.0	179.1	73.7	102.8
1981	167.2	31.3	164.8	79.0	91.3
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	62.2	115.6	144.0	29.4
1990	186.6	45.4	68.1	102.6	20.3

*Monthly average condom and oral pill users

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