Evaluation and Monitoring of the Reproductive Health in Korea

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Introduction

Korea has recently experienced an extraordinarily fast demographic transition with her successful implementation of the population control policy that started in 1962, and this has occurred simultaneously with rapid socioeconomic development. Between 1960 and 1987, the nation's total fertility was reduced from 6.0 to 1.6, and further declined to 1.4 in 1999. The steep fertility decline has brought in its wake profound changes in the composition of the population. Major inevitable consequences of the rapid fertility decline include the growth of the elderly population and the shrinking of the labour force.

The societal transition, not only demographically but also socio- economically, has forced policy-makers to respond and prepare for the challenges for the 21st century. Accordingly, the government adopted new directions and strategies of the population policy in 1966, which focused primarily on population quality and social welfare rather than on demographic arenas(Cho, 1966). In the process of this new policy formulation, the 1994 ICPD programme of action and recommendations were also reflected.

The major goals of the new population policy were; 1) to maintain the below replacement levels 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 improve the imbalance of sex ratio at birth and to reduce the incidence of induced abortions, 4) to

tackle the sex related problems of the youth and adolescents, 5) to empower women by expanding employment opportunities and welfare services for them, and 6) to improve work opportunities and provide adequate health care and welfare services for the elderly.

With the new population policy, the family planning programme has 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 programmes, such as family planning, maternal and child health and other social welfare programmes, 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 programme target population to cover the young unmarried population, to prevent premarital pregnancy.

In the past years, the success of the national family planning programme has been largely attributed to the efficient programme management with emphasis on the contraceptive target allocation and monthly programme evaluation and monitoring through routine service statistics system with a broader management system. However, the management system for reproductive health programmes since the new population policy in 1996 has not well functioned, due largely to several problems such as lack of unified coordination, data collection, and low utilization of data. This paper has been prepared in an effort to share our experience in the management development aspect of family planning and reproductive health programmes in Korea.

Evaluation and Monitoring System for RH Programmes

In Korea, the national family planning programme, as a major means of population control policy, has been a key element in reproductive health programmes since 1962. This programme includes the demographic target of reducing the annual population

growth rate and the total fertility rate, and it was vigorously implemented as a categorical programme through the successive five-year economic development plans. The strength of this categorical family planning programme 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.

Programme evaluation activities had come to rely entirely on sample surveys, monthly service statistics, reports, and records. Nationwide fertility/KAP surveys and contraceptive acceptors' follow-up surveys have been conducted for the use of programme planning and evaluation on a regular basis at three year intervals since the beginning of the programme. Since the inception of the national family planning programme in 1962, the routine evaluation activities based on the monthly service statistics had been implemented for managerial purposes under the leadership of Korea Institute for Health and Social Affairs(KIHASA), where processed monthly service statistics information into reports returned to the government (Ministry of Health and Welfare : MOHW), provinces, health centers, and other programme agencies on a regular basis. Several indicators had been utilized such as target/achievement by methods, exceeding achievements of IUD and sterilization, the proportion of sterilization and IUD acceptors with two children or less, accuracy of the statistics, etc. These monthly feedback reports made it possible for programme managers at provincial and health center levels to compare the performance of their area with other provinces and health centers.

So far, the monthly evaluation and feedback information system had been very useful and effective for motivating programme personnel at the provincial and local levels to recruit younger acceptors with two children or less and to achieve more than their targets. Technical supervision and control over the whole process of programme operation was formally done within

MOHW. The government had organized and operated Family Planning Evaluation Units at central, provincial, and local levels in 1983 to make the supervisory function effective. e central evaluation unit was composed of senior staff personnel from MOHW, KIHASA, and Planned Parenthood Federation of Korea(PPFK). This team visited province, city and county level facilities on a monthly basis to supervise and monitor administrative and technical field activities, uncover problems, and examine and develop policies for improvement.

Since the population policy has been shifted from the population control to the population quality and welfare in 1996, the monthly evaluation system for family planning programme has gradually disappeared because of the high contraceptive practice rate and below replacement fertility level. However, evaluation and monitoring activities for population and family planning programmes have been to rely almost entirely on the routine national surveys such as the National Fertility and Family Health Survey conducted by KIHASA on the basis of three-year interval, Population and Housing Census by the National Statistical Office(NSO) on the basis of five-year interval, and Annual Vital Statistics Report by NSO. Implementation of the reproductive health requires a very broad range of activities including development and provision of programmes. However, there has been no responsible agency to coordinate the reproductive health programmes, and to unify RH data collection, processing and dissemination among different departments and vertical RH programmes in the government. In other word, individual programme evaluation and monitoring activities related reproductive health has been carried out by each different department and private agency.

In 1999, KIHASA has prepared a comprehensive evaluation report, which focuses on reproductive health, including FP and MCH, adolescent sexuality, STI and HIV/AIDS, empowerment of women, family welfare, elderly health and welfare, population distribution, population and environmrnt, and NGOs' roles in the

implementation of the ICPD Programme of Action(Cho, 1999).

Current Status of Reproductive Health

Since the 1994 ICPD, the Korean government begun efforts in the right direction when it adopted a new population policy in 1996, which focused on reproductive health programmes including family planning, maternal and child health, STI and HIV and AIDS, and adolescent reproductive health. However, an integrated and comprehensive reproductive health scheme, in terms of organizational and functional integration, has not yet been fully developed, and its importance is not well recognized by policy makers. In spite of the shift of the population policy in Korea, the total fertility rate in Korea(Table 1) continuously decreased from 1.56 in 1997 to 1.47 in 2000.

Table 1. Trends in Total Fertility Rate(TFR), 1960～2000

(Unit: per woman)

Year	1960[1)]	1974[2)]	1984[2)]	1987[2)]	1993[2)]	1997[2)]	1998[1)]	1999[1)]	2000[1)]
TFR	6.0	3.6	2.1	1.6	1.8	1.56	1.48	1.42	1.47

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.

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.

Table 2. 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.

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) increased from 44.2 percent in 1976 to 79.3 percent in 2000. 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 programmes to self-support programmes, through the health insurance system and private sector. The government budget for family planning declined rapidly from 31.8 billion won in 1986 to 0.4 billion won in

2000.

Table 3. Contraceptive Practice Rates of Currently Married Women, by Method, 1976～2000

(Unit: %)

Methods	1976	1982	1988	1991	1994	1997	2000
Female sterilization	4.1	23.0	37.2	35.3	28.6	24.1	18.3
Male sterilization	4.2	5.1	11.0	12.0	11.6	12.7	13.0
IUD	10.5	6.7	6.7	9.0	10.5	13.2	13.7
Oral pill	7.8	5.4	2.8	3.0	1.8	1.8	2.1
Condom	6.3	7.2	10.2	10.2	14.3	15.1	16.5
Other methods	11.3	10.3	9.2	9.9	10.6	13.6	15.7
Total	44.2	57.7	77.1	79.4	77.4	80.5	79.3

Source: Kim, Seong-Kwon, et al., 2000 National Fertility and Family Health Survey Report, Korea Institute for Health and Social Affairs, 1997.

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 2000, women in the 35～39 year age group show the highest contraceptive practice rate with 89.3 percent, followed by those in the 40～44 age category with 87.7 percent. Female and male sterilization accounted for 31 percent of the total practice rate in 2000. 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.

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 13.7 percent in 2000. 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 2.1 percent in 2000, 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 2000, 86.3 percent of married women said that they had adopted contraception for pregnancy termination, and only 9.3 percent were found to have adopted contraception for birth-spacing, while the remaining 3.9 percent reported they had adopted contraception for other purposes. As for the cost of contraceptive services in 2000, 50.6 percent of all female sterilization acceptors and 58.7 percent of total vasectomy acceptors were supported by the government.

In contrast, in 2000, 91.4 percent of condom users and most 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 2000, 10.7 percent of female sterilizations and only 8.2 percent of male sterilization acceptors received services under the medical insurance scheme.

Maternal and Child Health

In Korea, the maternal and child health programme has been active since the pmulgation 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 programme, family planning and other primary health programmes, the government integrated individual family planning, maternal and child health and tuberculosis workers in health centers into health workers since 1985.

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 in 1985 to 100.0 percent in 2000. As for post-natal care, the percentage of women with new-borns that visited maternity hospitals increased from 52.3 percent in 1988 to 85.0 percent in 2000. According to the 2000 national fertility survey, 99.9 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. 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 2000, among women who had given birth after 1998, only 10.2 present breastfed, while 24.8 percent bottlefed. The remaining 65.9 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 encourage breast-feeding, 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.

Table 4. Trends in Institutional Delivery, by Institution, 1985~2000

(Unit: %)

	1985	1988	1994	1997	2000
Institutional delivery	75.8	87.8	98.8	99.7	9.9
a) general hospitals	17.8	23.6	31.8	39.0	31.5
b) clinics	45.8	53.4	64.4	59.3	67.7
c) midwiferies	9.1	7.4	2.0	1.1	0.3
d) health centers	2.5	3.4	0.6	0.3	0.4
Non-institutional delivery	24.8	12.2	1.2	0.3	0.1
Total	100.0	100.0	100.0	100.0	100.0
(N)	(3,541)	(2,843)	(1,932)	(1,163)	(1,338)

* includes general hospitals.
Source: Same as Table 3.

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.

The induced abortion rate has been increasing since the start of the family planning programme by the government in 1962.

As the data in Table 5 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 1990～1999 for the 20～24 and the 25～29 age groups.

As for the reasons for induced abortion(Table 6), 48.4 percent of married women who experienced induced abortion replied that they had to resort to abortion because they do not want children, and 13.1 percent said they had the abortion for birth-spacing.

Table 5. Changes in Induced Abortion Rates, 1975～1999*

Age category	1975	1984	1990	1996	1999
20～24	63	91	186	79	53
25～29	86	146	112	51	33
30～34	158	115	60	49	33
35～39	153	40	21	16	12
40～44	75	20	6	3	1

Note: this is the number of abortions per 1,000 married women.
Source: Same as Table 3.

As for pregnancy wastage, more than 34 percent of 1999 pregnancy outcomes are accounted for by pregnancy wastage, and 70.6 percent 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 MCH services, centered on 23 public health centers of the total number of 245 centers in the nation, aims to

improve reproductive health with emhasis on 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.

Table 6. Percentage Distribution of Married Women Who Have Experienced Induced Abortion, by Reason, 1994 and 2000

(Unit: %, persons)

Reasons	1994	1997	2000
Child unwanted	58.4	49.7	48.4
Birth-spacing	11.1	11.0	13.1
Health of mother	9.7	10.6	10.0
Fetal impairment	5.1	3.6	4.7
Pre-marital pregnancy	3.3	4.0	5.1
Family discord	1.7	1.9	1.1
Economic reasons	3.7	7.3	6.5
Sex pre-selection(daughter)	1.7	2.6	2.4
Other	5.3	9.3	8.7
Total	100.0	100.0	100.0
(N)	(2,541)	(2,394)	(2,508)

Source: Same as Table 3.

Adolescent's 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[1] 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[2], increased from 24.3 percent in 1991 to 32.4 percent in 1993 and 47.9 percent in 1997(Lee, 1998).

The 1997 national survey data(KIHASA) 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 seeking medical care for abortion complications.

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

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. Currently, 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.

STD and HIV/AIDS

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 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 7. Trends in the Number of Sexually Transmitted Disease Infected People, 1996 and 2000

(Unit: persons)

	Gonorrhea	Syphilis	Non-gonorrheal Urethras	Others	Total
1996	6,461	3,099	24,157	4,562	38,279
1997	6,895	2,712	23,796	5,358	38,761
1998	7,454	2,021	23,460	5,285	38,220
1999	6,689	1,659	21,119	6,594	36,061
2000	6,517	1,173	20,619	3,236	31,545

Source: National Institute of Health(NIH), Monthly STD Statistics, 2000.

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 1,439 in June of 2001(refer to Table 8). The total number of infected is composed of 1,256 males and 183 females, and of them 316 have already died of AIDS.

By year, the number of HIV positive infected has increased, and 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.

The latest statistics show that 1,167 the total 1,439 positive patients were exposed to the epidemic through sexual intercourse(333 f them through homosexuality) and 21 of them through blood transfusion. By age bracket, 64.8 percent of the total 1,439 HIV positive patients are in the 20-30 year age

bracket(Table 9). 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 programmes need to be developed to reach those in the 20～30 age category who are most likely to contract sexually transmitted diseases and HIV/AIDS.

Table 8. Trends in HIV Infected People, 1985～2001

(Unit: persons)

	Total	1985～95	1996	1997	1998	1999	2000	2001 (June)
Total	1,439	169	102	124	129	186	219	159
Male	1,256	146	90	107	111	160	194	138
Female	183	23	12	17	18	26	25	21
Patients	220	8	22	33	35	34	52	23

Source: Same as Table 7.

As can be seen from Table 10, sexual intercourse is the most pronounced route of HIV infection, which accounts for 89.0 percent of HIV infected persons after excluding those under examination. Among those infected by sexual intercourse, homo-sexuality accounted for 25.4 percent. 523 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. 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.

Table 9. Sex and Age Pattern of the HIV Infected in June 2001

(Unit: person)

Age Group	Total	Male	Female
Total	1,439(316)	1,256(283)	183(33)
0～ 9	10(2)	10(2)	1(-)
10～19	23(1)	19(1)	4(-)
20～29	414(36)	351(33)	63(3)
30～39	519(125)	459(110)	60(15)
40～49	282(86)	248(77)	34(9)
50～59	137(43)	122(40)	15(3)
60+	54(23)	48(20)	6(3)

Note: 1) The age of the infected when detected.
2) ( ) is the number of deaths.
Source: Same as Table 7.

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.

Table 10. HIV-Infected Persons by Route of Infection Transmission (1985~2001)

(Unit: persons)

Total	Sexual intercourse				Blood transmision		Others	Under examination
	Sub total	Abroad	Domestic	Homo-sexual	Abroad	Domestic		
1,439	1,167	311	523	333	10	11	122	129

Source: Same as Table 7.

Imbalance of Sex Ratio at Birth

Since the mid 1980s, when the fertility rate reached the replacement level, the prevalence of sex-selective induced abortions using procedures to determine the sex of the fetus has resulted in an imbalance in the sex ratio at birth. The sex ratio at birth in Korea was normal up to 1982, but it increased thereafter. The imbalance of the sex-ratio at birth has been improving annually, from a peak of 117 in 1990 to 110 in 2000, 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 sex imbalance, the government made a revision to the then existing medical law in October, 1996. 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.

Table 11. Sex Ratio at Birth1) by Birth Order, 1980～2000

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
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
1999	109.6	105.6	107.6	143.1
2000	110.2	106.2	107.4	143.9

Note: 1) number of male live births per 100 female live births.
Source: National Statistical Office, Vital Statistics Reports, 1980～2001.

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. In addition, 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.

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 programmes, 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 programme managers. The following policy directions should be sought for successful implementation of reproductive health programmes in Korea as established in the ICPD Programme of Action.

First, to ensure the success of the integrated reproductive health approach, pertinent programme agencies involving reproductive health should be organizationally and functionally integrated. Integration efforts should be directed toward: 1) unifying the entire programme-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, 4) establishing a unique programme management system with an integration approach, and training programmes of health personnel at the local levels. It is urgent that an innovative scheme be developed for programme 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 programmes should be established. Since reproductive health programmes require multi-sector approaches involving various ministries, departments, institutes and non-governmental organizations, effective coordination among organizations will help to ensure smooth programme implementation and avoid any duplication of efforts.

Third, the government should increase the programme budget

for additional reproductive health services. Central and local governments should share budgets for reproductive health programmes, and expand their financial support for private organizations and non-governmental organizations, so that major programmes, 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 programmes. Following the National Health Promotion Act enacted in 1995, the government has implemented health promotion demonstration programmes at 18 health centers since 1997. The demonstration programme 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 programmes should be developed through close coordination between health centers and related private organizations. Comprehensive indicators for monitoring of reproductive health programmes 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 programme managers understand the importance of reproductive health for its success.

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<abstract>

In Korea, the national family planning and maternal and child health programmes have been a key element in reproductive health programmes since 1962. As a result of a success in the national family planning programme together with socio-economic development, Korea has experienced a drastic decline in fertility and mortality. However, the low fertility has resulted in an imbalance of sex ratio at birth, an increase in the old population, adolescent's sexuality, and a high prevalence of induced abortion, and STD and HIV/AIDS. In an effort to deal with these new problems, the government adopted a new population policy with emphasis on reproductive health for improving population quality and welfare in 1996. This paper explains the emerging issues, future policy directions and options on reproductive health in Korea.