

*Women's Health Status and
Policy Issues in Korea*

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Chapter 1

Introduction

Background

From the 1975 International Women's Year to the Beijing Declaration and the Platform for Action in 1995, international consensus has been reached on removing all forms of discrimination against women. The international community has strived to achieve the equal participation of women in economic, social, cultural and political decision-making and an equal share of the benefits from development. Marked gender disparities, however, persist.

When it comes to the area of health, which is the basis of all areas related to the improvement of the status of women and their children, women still suffer from relative disadvantages. The World Health Organization(WHO) emphasizes that priority should be given to health programs targeting women throughout their life-cycle, particularly in basic health and reproductive health. Moreover, the area of health is one of the 12 critical areas of concern according to the Platform for Action of the 1995 Beijing World Conference on Women. Women have a basic right to

enjoy full physical and mental health. According to the Constitution of the WHO, health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity(WHO, 1992).

Women have unique health needs that require specific attention within the health sector. They have health problems associated with the reproductive process; health problems related to women's socioeconomic status, including violence, rape and other forms of sexual harassment and abuse; and health problems and a need for support that relate to women's multiple roles in society.

Korean women's health has improved markedly in recent years due to remarkable economic growth, improved public hygiene, better nutrition, and expanded health insurance and medical facilities. The average life expectancy for women is 75.7 years, which is 8.0 years longer than the 67.7 years for men. Korean men's life expectancy at all ages is less than women's.

The social status of Korean women is still low despite the socio-economic development of Korea, and gender inequalities are pervasive in Korean society. Consequently, as might be expected, gender inequality can be found in the health area.

Health policy decisions in Korea are not gender-sensitive yet. Women's health issues have largely

gone unnoticed in Korea because people are less conscious of the need for a gender perspective on health. Mainstream methodologies and mainstream data do not necessarily reflect either women's objective or their subjective experiences of health, illness and disability. Therefore, gender-desegregated, gender-sensitive and gender-specific indicators in non-reproductive areas of health are needed.

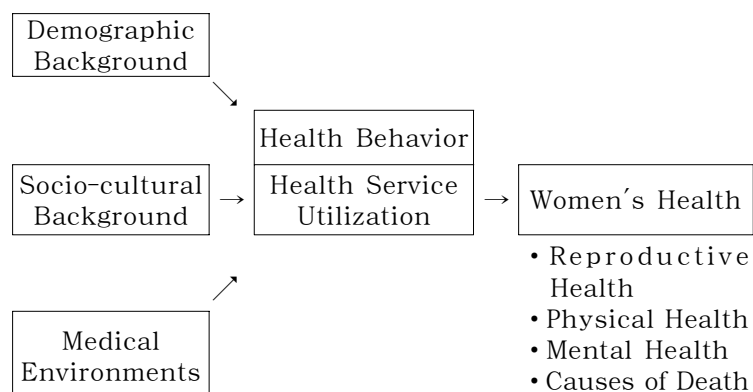
This paper aims to provide basic knowledge and ideas for the introduction of gender-balanced health policies which will ensure women's health as a fundamental human right. To achieve this objective, this paper will review the health status of Korean women and the current social environment impacting women's health. Based on this review, policy recommendations will be presented.

Framework and Method of the Study

Considering women's health and the social support needed to enhance women's health, following themes will be discussed based on the framework of Figure 1. First of all, the health status of Korean women in terms of reproductive health, physical health, mental health, and the leading causes of death will be evaluated. Secondly, health behaviors, including smoking, alcohol consumption, exercise, weight control

eating patterns and preventive behaviors, and the current status of medical utilization of Korean women will be reviewed. Whether women are practicing preventive health behaviors to reduce risk factors and using medical services enough will be the main points. Thirdly, the current social environment in terms of medical, demographic, and socio-cultural factors impacting women's health will be examined.

Figure 1. Framework
(based on Green's Precede Framework)



For this purpose, the existing statistical data is analyzed. Both national statistics produced by the government and the national data set produced by government research institutes were used to explore women's health status, demographic features, and the social environment. In particular, the National Fertility and Family Health Survey data¹⁾ by Korea Institute

for Health and Social affairs(KIHASA) are used to explore women's reproductive health status. In addition, the National Health Interview Survey²⁾ by KIHASA is used to describe the status of women's health, health behavior and health service utilization. In the case of violence against women, several studies by the Korea Women's Development Institute and Korean Institute of Criminology are used. International comparisons are made in cases where the data is available.

1) National Fertility and Family Health Survey is conducted every three years in Korea nationwide. KIHASA conducted the most recent survey in 1994. Surveyors visited approximately 11,000 household and interviewed 6,060 married women.

2) National Health Interview Survey is conducted by KIHASA every three years in Korea nationwide from 1989. KIHASA conducted the most recent survey in 1995. Surveyors visited approximately 6,791 household and interviewed 22,675 individuals.

Chapter 2

Health Status of Korean Women

Reproductive Health

Regulation of Reproduction

Contraception

Reproductive health can be achieved when women can safely give birth to a desired number of children at the desired time. The contraceptive practice rate and the experience rate of induced abortions are important indicators of women's reproductive health status. According to the 1994 National Fertility and Family Health Survey, 77.4% of all married women aged 15~44 practiced contraception. This means that almost all married women, with the exception of those experiencing menopause, those naturally sterile, and those temporarily separated from their husbands (these women comprised 3.5% of all married women), practice family planning.

Generally, most Korean couples employ female contraceptive measures rather than male ones. In 1994, the use of contraception by women was 51.5%

compared to only 25.9% by men. Female sterilization was the most common form of contraception, although it is an unfavorable method due to the possible side effects. In addition, tubaligation is chosen more frequently in rural areas than urban areas; it was chosen by 26.8% of women in urban areas and 37.1% in rural areas. On the other hand, condoms are more frequently used in urban areas than in rural areas.

As Table 1 shows, there are inter-country variations in contraceptive use; the use of contraception by men is 28%, 32%, 49% for the U.S.A., U.K. and Japan respectively. In the U.K., the vasectomy rate is even higher than tubaligation. These facts reflect the reality that social attitudes have an influence on the choice of contraceptive methods. The comparatively low rate of contraceptive use by men in Korea reflects social attitudes in Korea, which place the responsibility on women to control reproduction in addition to giving birth.

Table 1. Percent Distribution of Contraceptive Users by Method

(Unit: %)

	Whole country	Urban	Rural	U. S. A (1988)	U. K. (1986)	Japan (1992)
Total	77.4	77.1	78.4	74.0	81.0	64.0
Tubaligation	28.6	26.8	37.1	23.0	15.0	3.0
Vasectomy	11.6	11.6	11.6	13.0	16.0	1.0
IUD	10.5	10.3	11.4	2.0	8.0	3.0
Oral Pill	1.8	1.8	1.8	15.0	19.0	1.0
Condom	14.3	15.8	7.4	11.0	16.0	48.0
Others	10.6	10.9	9.1	11.0	12.0	18.0

Sources: 1) Hong et al., *1994 National Fertility & Family Health Survey*, p.221.

2) U.N., *World Contraceptive Use*, 1994.

By including family planning as part of its social development policies, the Korean government has played an active role in family planning policies. Government policy concerning contraceptive distribution, however, has changed recently. All contraceptive methods, except the diaphragm, had been distributed through government channels at little or no charge. Once replacement level fertility was achieved, however, government support began to substantially decrease in the 1990s.

Contraception has two functions; one is family planning and the other is the protection of maternity. The government should continue to provide family planning services as part of the comprehensive health

care programmes to protect maternity rather than as a way to reduce population growth.

Induced Abortion

Induced abortions are not in principle allowed under the Maternal and Child Health Law in Korea. Despite the regulations, induced abortions are widely available but performed discreetly in Korea. This restriction imposes an economic burden on the women who obtain these services, and safe medical practices can not be guaranteed.

According to the 1994 National Fertility Survey, 49% of all married women claimed to have had an experience of induced abortion, down from 54% in 1991(see Table 2). The highest rate of induced abortions occurred in the late 1970s and has decreased gradually since.

Table 2. Trend in the Induced Abortion Experience Rate of Married Women Aged 15~44: 1976~1994
(Unit: %)

Characteristics	1976	1979	1985	1988	1991 ¹⁾	1994
Total	39	48	53	52	54	49
Urban	46	53	55	54	55	49
Rural	29	40	48	47	49	49
Age						
15~24	16	19	22	27	29	21
25~29	27	36	42	41	40	36
30~34	46	54	61	57	55	51
35~39	50	59	63	63	60	58
40~44	45	56	67	62	65	60
Total Induced Abortion Rate per Married Women	0.9	1.1	1.1	1.0	1.1	0.8

Note : 1) The figures in 1991 are for women aged 15 to 49.
Source: Hong et al., *1994 National Fertility & Family Health Survey*, p.157.

In spite of the high rates of family planning, unwanted pregnancies among married women due to contraceptive failure and the practice of prenatal sex selection related to son preference have resulted in a high induced abortion rate. Approximately 61% of all pregnancies were terminated by live births, 28.3% by induced abortion, 8.2% by spontaneous abortion and 0.4% by stillbirth(see Table 3).

Approximately 17% of those who had induced abortions experienced side effects, including bleeding, stomachaches, anemia, edema, and inflammation(Hong, 1994: 167).

Table 3. Pregnancy Outcome by Residence
(Unit: %, number)

	Whole country	Urban	Rural	U. S. A.
All pregnancies	100.0 (15,316)	100.0 (12,384)	100.0 (2,932)	100.0 (6,563,000)
Births	61.0	59.7	66.3	62.6
Stillbirths	0.4	0.3	0.6	-
Abortion	8.2	8.5	6.8	13.7
Induced abortion	28.3	29.2	24.6	23.7
Currently pregnant	2.1	2.2	1.6	-

Source: Hong et al., *1994 National Fertility & Family Health Survey*, p.78.

Although few studies have been conducted on the rate of induced abortions among unmarried women, we believe it deserves more attention. According to a study conducted in a medium-sized city in 1990, unmarried women accounted for 32.9% of all induced abortions performed(Hong, 1990). Considering the under-reporting of induced abortion experiences among unmarried women, we estimate the actual number of induced abortions among unmarried to be much higher. Some of the reasons for this may stem from increased sexual activity among the youth and the unmarried.

Sex Preference for Sons

According to the 1994 National Fertility and Family

Health Survey, approximately 61% of women expressed a belief in the necessity of having a boy(see Table 4). Although this is lower than the 71.2% figure of 1991, it indicates that a strong son preference still exists. In rural areas son preference is especially strong as evidenced by the fact that 74% of women expressed opinions supporting son preferences. Son preferences result in the sex-selective abortions, which has grave social, demographic, and ethical implications, and future trends in the sex ratio at birth will need careful monitoring.

Sex-selective induced abortions after receiving sex identification tests are estimated at about 25,000, comprising approximately 5% of all females born in 1992. According to the 1994 National Fertility and Family Health Survey, among the fetus sex identification tests that were performed, more than 17% of the female fetuses were aborted, while only 3.2% of the male fetuses were aborted(see Table 5).

Table 4. Son Preferences: Expression of the Necessity of Having a Boy

	(Unit: %)	
	1991	1994
Total	71.2	60.6
Urban	69.1	57.7
Rural	79.5	74.2

Source: Hong et al., *1994 National Fertility & Family Health Survey*, p.139.

Table 5. Pregnancy Outcome by Sex of Fetuses
(Unit: %)

	Births	Still Births	Abortion	Induced Abortion	Currently Pregnant	Total (Number)
Male Fetus	94.6	0.3	0.2	3.2	1.8	100.0 (709)
Female Fetus	81.1	0.3	-	17.4	1.3	100.0 (598)
Total	88.4	0.3	0.1	9.7	1.6	100.0(1,308)

Source: Hong et al., *1994 National Fertility & Family Health Survey*, p.150.

Selectively induced abortions of female fetuses appears to have contributed to the rising imbalance in the sex ratio(males per 100 females) at birth. A rising sex ratio at birth has been recorded since 1981, at which time the sex ratio at birth was 107.2. The ratio increased to 109.4 in 1985, and to 115.5 in 1994(see Table 6). This is very high compared to the sex ratios of industrialized countries(see Table 7). The distortion of the sex ratio becomes much greater as parity increases.

Table 6. Trend in the Sex Ratio at Birth: 1980~1994
(Unit: male births per 100 female births)

Year	Total	1st birth	2nd birth	3rd birth	4th birth+
1980	105.3	106.0	106.5	106.9	110.2
1981	107.2	106.3	106.7	107.1	112.9
1982	106.8	105.4	106.0	109.2	113.6
1983	107.4	105.8	106.2	111.8	120.0
1984	108.3	106.1	107.2	116.9	128.1
1985	109.4	106.0	107.8	129.2	146.8
1986	111.7	107.3	111.2	138.6	149.9
1987	108.8	104.7	109.1	134.9	148.8
1988	113.3	107.2	113.3	165.4	183.3
1989	111.8	104.1	112.5	183.1	201.1
1990	116.6	108.6	117.2	190.8	214.1
1991	112.5	105.8	112.6	181.4	201.3
1992	113.8	106.3	112.6	194.1	220.1
1993	115.5	106.6	114.8	205.3	246.7
1994	115.5	106.1	114.3	205.9	237.7

Source: National Statistical Office, *Annual Report on the Vital Statistics*, Various Years.

Table 7. Sex Ratio at Birth in Major Countries

Country	Year	Sex ratio	Country	Year	Sex ratio
U.S.A	1988	105.0	Japan	1989	105.6
France	1986	105.2	China	1989	113.9
U.K.	1989	105.1	Taiwan	1990	110.2
Germany	1989	105.1	Hongkong	1989	105.1
			Korea	1990	116.9

Sources: 1) U.N., *Demographic Yearbook*, 1990,
2) KIHASA and UNFPA, *Sex Preferences for Children and Gender Discrimination in Asia*, 1996.

Protection of Maternity

Maternal and Child Health

The rapid fertility decline and government efforts have engendered an improvement in maternal and child health. Almost all women(99.2%) received prenatal care during their last pregnancy, and the average frequency of prenatal care received was ten visits in 1994(see Table 8). Moreover, almost all babies(98.8%) were delivered in medical institutions, a dramatic improvement from the 87.7 percent recorded in 1988.

The caesarean section rate has increased from 9.6% in 1986 to approximately 28% in 1993 according to health insurance claims submitted to the National Federation of Medical Insurance. The fact that the medical fees for caesarean section are as much as four times those for vaginal births is undoubtedly one of causes of the high cesarean section rate.

Although maternal mortality is no longer a major problem in Korea, it is still higher than western industrialized countries in spite of the high level of pre-natal care and the safe-delivery rate(see Table 9); maternal mortality rate is 3.0, 0.9, 1.2 per 10,000 live births for Korea, U.K, and U.S.A. respectively³⁾.

3) Korea: Park and Hwang, *Direction of Maternal and Child Health Policy*, 1993.3(in Korean); U. K. and U.S.A.: *The State of World Population*, UNFPA, 1996.

The main causes of maternal death are puerperal complications, pregnant intoxication, and bleeding(Park and Hwang, 1993).

Table 8. Percent Distribution of Place of Delivery by Area

	(Unit: %, number)	
	1991	1994
Total	100.0(2,151)	100.0(1,932)
General Hospital	-	31.8
Hospital	91.0	21.3
Clinic	-	43.1
Midwifery Clinic	5.1	2.0
Health Center	2.0	0.7
Home & others	1.9	1.2

Source: 1) Hong et al., *1994 National Fertility & Family Health Survey* (Latest births among the live births since 1990).
 2) Kong et al., *1991 National Fertility & Family Health Survey* (Latest births among the live births since 1987).

Maternity Leave and Child-care

Social support for child rearing is not fully set in Korea. For working women it is not easy to care for children. Child care leave provisions were introduced in 1987 through the Equal Employment Opportunity Act. Under this Act employers must grant requests for leave under any circumstances when a female worker with a child under one year old requests time off to take care of the child. They can leave for a maximum of one year, including the paid maternity leave before and after childbirth(60 days). This period

is very short compared to other industrialized countries(see Table 9). Because companies have to pay the entire costs of maternity protection, the employment of female workers is discouraged. Hence, the government should share the responsibilities of maternity protection. Moreover, day-care centers, especially day-care facilities at the workplace, are not sufficient(see Table 10). Fortunately, the government has recently become interested in the child-care issue. Expanding child-care facilities through the mobilization of private resources is one of ten policy priorities for the advancement of Korean women.

Table 9. Maternity Leave Benefits(1990)
(Unit: week)

Country	Maternity Benefits	Country	Maternity Benefits	Country	Maternity Benefits
Austria	16	Greece	15	Portugal	13
Belgium	14	Ireland	14	Spain	16
Canada	15	Italy	20	Sweden	65
Denmark	28	Japan	14	Switzerland.	8
Finland	53	Luxemburg	16	U. K.	18
France	16	Netherlands	16	Korea	9
Germany	14	Norway	35		

Source: Gauthier, *The State and The Family*, 1996, p.174.

Table 10. Estimation of Day Care Centers' Coverage for
the Children (0~5 years) of Working Mothers
(Unit: facilities, persons)

Years	Children of Employment 0~5 Years (A)	Rate of Women 25~34 Years (B)	Children, 0~5 Years of Working Mothers (A×B)	No. of Institutions	No. of Children under Care (C)	Coverage Rate (C/A×B)
1992	3,931,646	32.85%	1,291,522	4,513	123,297	9.55%
1993	3,948,777	32.85%	1,297,173	5,490	153,105	11.80%
1994	3,966,098	32.85%	1,302,863	6,086	191,748	14.70%

Source: Korean Women's Development Institute, *Statistical Yearbook in Women*, 1995. p.280.

General Health

Physical Health

Prevalence of Illness

According to the '95 National Health Interview Survey, the morbidity rate over the past two weeks from the time of the survey was higher among women than among men. The highest morbidity rates were found among women in their fifties and older (see Table 11).

Table 11. Morbidity Rate over the Past Two Weeks
(Unit: spell per 1,000 persons)

	Average	0~4	5~9	10~19	20~29	30~39	40~49	50~59	60~69	70+
Total	477	483	348	217	333	435	552	749	965	867
Male	378	498	384	209	261	322	395	536	730	749
Female	570	465	304	226	396	544	712	946	1,140	924

Source: Nam et al., *1995 National Health Interview Survey*, p.165.

The prevalence of chronic diseases was also higher among women than men. The differences in the prevalence of chronic conditions between women and men generally became greater as the age of the respondents' increases(see Table 12).

Table 12. Prevalence of Chronic Conditions
(Unit: spell per 1,000 persons)

	Total	0~19	20~29	30~39	40~49	50~59	60~69	70+
Total	431	138	274	400	562	832	1,170	973
Male	335	140	234	314	432	616	876	816
Female	521	136	303	483	695	1,031	1,279	1,048

Source: Nam et al., *1995 National Health Interview Survey*, p.122.

Above data show that higher rates of morbidity are found among women. Several reasons for these higher morbidity rates can be identified. First of all, women have more opportunities to acquire risks, from more contact with young children and from more emotional distress. Because mothers have more contact with their children than fathers do, they tend to develop infectious diseases transmitted by children. Also, women feel more psychological distress such as anxiety, depression, guilt, and conflicting demands, on a day-to-day basis and over their lifetimes than men do (Nathanson, 1975). In addition, women tend to label their symptoms as physical illness, and assess their illnesses and injuries as more severe and serious than men do. Higher rates of morbidity could come about because women feel "sick role" are highly linked to "feminine."

Ten Leading Causes of Chronic Illness

There are some differences between males and females when it comes to the leading causes of chronic morbidity, with musculosclerotic disease being the major cause among women and peptic ulcer and gastritis being more common among men(see Table 13).

Table 13. Ten Leading Causes of Chronic Morbidity
(Unit: %)

Ranks	Male	Prevalence
1	Peptic Ulcer & Gastritis	50.76
2	Dental Caries	31.89
3	Other Musculosclerotic Disease ¹⁾	30.62
4	Hypertension	21.69
5	Chronic Obstructive Pulmonary Disease	19.50
6	Arthritis	19.23
7	Diabetes	16.77
8	Chronic Sinusitis	17.68
9	Chronic Liver Disease	15.95
10	Hemorrhoids	11.12
Ranks	Female	Prevalence
1	Other Musculosclerotic Disease ¹⁾	83.41
2	Arthritis	72.90
3	Peptic Ulcer & Gastritis	77.34
4	Dental Caries	34.01
5	Hypertension	31.45
6	Heart Disease	17.43
7	Periodontal Disease	17.09
8	Genito-Urinary Disease	15.81
9	Chronic Obstructive Pulmonary Disease	17.52
10	Diabetes	15.42

Note : 1) All Musculosclerotic Disease except Arthritics.
Source: Nam et al., 1995 *National Health Interview Survey*,
pp.123~124.

Limitation of Activity

The average days of restricted activity per person in the past two weeks were 0.25. No differences between men and women appeared in this respect(see Table 14). Furthermore, the average days of being confined to bed due to disability was 0.15, and the average number of bed days increased as people's age increased. The longest period of bed days was found among men in their seventies and older(see Table 15).

Table 14. Restricted-activity Days per Person in the Past Two Weeks

(Unit: days)

	Total	0~4	5~9	10~19	20~29	30~39	40~49	50~59	60~69	70+ (65+)
Total	0.25	0.19	0.07	0.07	0.10	0.15	0.21	0.42	0.07	1.17 1.03
Male	0.25	0.17	0.07	0.07	0.12	0.17	0.24	0.52	0.73	1.29 1.07
Female	0.24	0.21	0.07	0.07	0.09	0.13	0.18	0.33	0.80	1.11 1.00

Source: Nam et al., *1995 National Health Interview Survey*, p.183.

Table 15. Number of Bed Days per Person per Two Weeks by Age

(Unit: days)

	Total	0~4	5~9	10~19	20~29	30~39	40~49	50~59	60~69	70+ (65+)
Total	0.15	0.10	0.05	0.05	0.06	0.10	0.13	0.25	0.50	0.74 0.68
Male	0.16	0.07	0.05	0.05	0.05	0.12	0.16	0.34	0.53	0.84 0.73
Female	0.15	0.13	0.04	0.06	0.06	0.08	0.09	0.18	0.48	0.69 0.66

Source: Nam et al., *1995 National Health Interview Survey*, p.184.

Among women aged 60 and over, 4.3% needed help in their daily activities around the house and 13.1% needed help with outside activities, which is higher than the statistics for men(see Table 16).

Table 16. Daily Activities of Persons over 60 Years of Age

(Unit: days)

	Total	Daily Activities in House			Daily Activities Outside		
		Able	Need Help	Unable	Able	Need Help	Unable
Total	100.0	95.7	2.8	1.5	88.8	4.8	3.4
Male	100.0	95.7	2.3	1.9	91.8	4.9	3.3
Female	100.0	95.6	3.1	1.2	86.9	9.6	3.5

Source: Nam et al., 1995 *National Health Interview Survey*. p.185.

Self-reported Levels of Health

In terms of self-reported levels of health, a higher percentage of women than men characterized their health as poor or fair rather than average(see Table 17).

Table 17. Self Reported Health Status

(Unit: %)

	Total	Excellent	Very good	Good	Fair	Poor
Total(22,675)	100.0	13.9	53.0	19.7	12.4	1.0
Male(10,974)	100.0	17.3	54.1	18.2	9.5	0.9
Female(11,701)	100.0	10.7	52.0	21.0	15.1	1.2

Source: Nam et al., 1995 *National Health Interview Survey*, p.120.

Mental Health

Prevalence Rate of Mental Disorders

The number of women with mental disorders was 3,493.62 out of 100,000 persons, which is almost twice of men(1,902.97). Especially, women have much higher rate of neurosis, physiological malfunction arising from mental factors, special symptoms or syndromes not elsewhere classified. 90% of women patients were diagnosed with "C" group disorders, which means neurosis, anxiety, personality disorders, non habitual drug abuse, depression, and behavioral problems(see Table 18). This is because women tend to express their emotional problems and visit doctors frequently.

The number of female patients hospitalized is only 4.7% of those diagnosed with mental disorders. On the other hand, 11.9% of similarly diagnosed male patients are hospitalized. Although there are no significant differences in the number of visits to the doctor between male and female patients, the average number of hospitalized days for male patients is greater. The average hospital days of female mental patients is 72.33 days per person, which is a much shorter length of stay than the 91.31 days for men. In sum, women tend to have higher morbidity rates but lower medical service utilization rates(See Table 19).

Table 18. Prevalence Rates of Mental Disorders by Sex and Age

(Unit: %)

Age	Male				
	Total	290~294 (A group)	295~299 (B group)	300~316 (C group)	317~319 (D group)
0~9	765.34	48.98	33.10	663.22	20.03
10~19	796.71	26.81	77.71	678.38	11.61
20~29	1365.97	26.76	410.12	921.89	7.20
30~39	2306.89	59.36	477.37	176.94	5.22
40~49	2967.05	102.88	378.66	2480.89	4.94
50~59	3491.27	137.28	320.33	3028.31	4.95
60~69	4046.34	215.28	279.96	3542.62	8.61
70+	4046.34	338.91	368.44	3314.50	14.49
Total (N=416,397)	1902.97	71.50	284.17	1537.87	9.45
Age	Female				
	Total	290~294 (A group)	295~299 (B group)	300~316 (C group)	317~319 (D group)
0~9	536.75	39.11	13.57	472.33	11.74
10~19	780.98	27.25	65.14	682.07	6.50
20~29	1936.01	31.63	345.97	1549.53	6.61
30~39	4244.74	57.36	445.94	3735.71	5.74
40~49	6257.01	81.17	410.22	5758.07	7.54
50~59	8146.84	120.85	418.68	7598.31	8.99
60~69	7664.55	225.97	357.65	7070.25	10.70
70+	4905.54	306.30	255.75	4330.15	13.32
Total (N=774,463)	3493.62	74.55	279.40	3131.66	8.01

Source: Nam et al., *Status and Policy Issues of the Mental Health*, 1994, pp.35~36.

Table 19. Utilization of Medical Services by the
Kinds of Mental Disorder and Sex
(Unit: %)

Kind	Hospitalization			Visits		
	Total	Male	Female	Total	Male	Female
1	16,230 (6.8)	12,777 (8.9)	3,453 (3.6)	71,113 (2.2)	34,371 (2.8)	36,742 (1.8)
2	166,439 (69.6)	95,539 (66.3)	70,900 (74.7)	629,004 (19.4)	314,249 (26.0)	314,756 (15.5)
3	52,135 (21.8)	34,040 (23.6)	18,095 (19.1)	253,774 (78.2)	857,324 (70.8)	1,673,450 (82.5)
4	4,275 (1.8)	1,765 (1.2)	2,510 (2.6)	7,615 (0.2)	4,590 (0.40)	3,025 (0.2)
Average Hospital Days	82.86	91.31	72.33	5.44	6.06	5.12
Total	239,079 (100.0)	144,121 (100.0)	94,958 (100.0)	323,506 (100.0)	1,210,534 (100.0)	2,027,972 (100.0)

Source: Cited in Nam et al., *Status and Policy Issues of the Mental Health*, 1994, p.53.

Prevalence of Depression

The prevalence of depression is also higher among women than men(women, 17.4%, men 12.6%)(Nam et. al., 1995). The main reasons for this can be traced to women's social roles. Housewives, generally, feel unchallenged, bored, and undervalued. On the other hand, employed women experience excessive demands on their time and attention. Because of social isolation or too much social involvement, women tend to feel frequently upset (Verbrugge, 1985).

Causes of Death

Leading Causes of Deaths

According to the National Statistical Office(1994), the first leading cause of death for both men and women is "diseases of the circulatory system" and the second leading cause is "neoplasms." However, "injury and poisoning" is the third highest cause for men and the fourth for women. Also, "symptoms, signs and ill-defined conditions" are the fifth for men and the third for women.

This indicates that cultural matters and the lack of data and studies on women's health could be the reason that such a large number of female deaths are recorded under the category of "symptoms, signs and ill-defined conditions."

Table 20. Ten Leading Causes of Deaths

Rank	Male
1	Diseases of the Circulatory System
2	Neoplasms
3	Injury and Poisoning
4	Diseases of the Digestive System
5	Symptoms, Signs and ill-defined Conditions
6	Diseases of the Respiratory System
7	Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders
8	Infectious and Parasitic Diseases
9	Mental Disorders
10	Diseases of the Nervous System and Sense Organs
Rank	Female
1	Diseases of the Circulatory System
2	Neoplasms
3	Symptoms, Signs and ill-defined Conditions
4	Injury and Poisoning
5	Diseases of the Digestive System
6	Diseases of the Respiratory System
7	Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders
8	Infectious and Parasitic Diseases
9	Diseases of the Skin and Subcutaneous
10	Diseases of the Nervous System and Sense Organs

Source: National Statistical Office, *1993 Annual Report on the Cause of Death Statistics*, 1994.

Neoplasms

Although neoplasms are the second leading cause of death for both men and women, the kinds of neoplasms frequently found are different by sex. For women, the leading type of cancer is uterine cancer, while breast cancer is third. The types of cancer related to women's reproductive function are 37.6% of the all types of cancer found in women, including uterine cancer, breast cancer, and ovarian cancer. For men the leading types of cancer are stomach cancer, lung cancer, liver cancer, and cancer of the reproductive organs is very rare for men. This indicates that women cannot free from biological conditions and the need for studies on cancer of the reproductive organs is great.

Table 21. Leading Cancer by Sex

Rank	Male	%	Rank	Female	%
1	Stomach Cancer	26.0	1	Uterine Cancer	22.8
2	Lung Cancer	16.2	2	Stomach Cancer	16.7
3	Liver Cancer	15.7	3	Breast Cancer	11.9
4	Colitis Cancer	7.7	4	Colitis Cancer	8.3
5	Esophagus Cancer	3.2	5	Lung Cancer	5.6
6	Bladder Cancer	3.1	6	Thyroid Gland Cancer	5.2
7	Leukemia	3.0	7	Liver Cancer	5.1
8	Gallbladder Cancer	3.0	8	Gallbladder Cancer	3.4
9	Larynx Cancer	2.1	9	Leukemia	2.7
10	Others	20.0	10	Others	18.3

Source: Ministry of Health and Welfare, *Report of Korean Cancer Registration Investigation*, 1994.

Chapter 3

Health Behavior and Medical Service Utilization

Health Behavior

Smoking

According to National Health Behavior Survey data, the current smoking rate among adults 20 to 59 years of age is 35.5%, which is relatively unchanged since 1989(35.8%). Looking at the trend of smoking rates by sex, however, the rate was found to be decreasing among men(from 70.8% in 1989 to 67.7% in 1995) and increasing among women(from 3.9% in 1989 to 5.0% in 1995).

Table 22. Trend of Smoking Rate by Sex
(Unit: %)

	1989	1995
Total	35.8	35.5
Male	70.8	67.7
Female	3.9	5.0

Source: Nam et al., *1995 National Health Behavior Survey*, p.300.

Looking at the trends by age group since 1989, the smoking rate among those who are 30 to 39 years of age decreased 4.2 percentage points(from 39.8% in 1989 to 35.6% in 1995), while the rate among those 20 to 29 years increased 5.1 percentage points(from 30.4% in 1989 to 35.5% in 1995). The rise was most marked among women between 20 to 29 years of age, which is an increase of 3.3 times(from 1.4% in 1989 to 5.0% in 1995).

The smoking rate among adult Korean males 15 years or older(61.0%) was the highest among major industrialized countries - Japan(59.8%), Germany(36.8%) and the USA(28.6%) - while the rate for Korean females was the lowest(see Table 24).

Table 23. Trend of Smoking Rate by Age and Sex
(Unit: %)

	1989		1995	
	Male	Female	Male	Female
Total	70.8	3.9	67.7	5.0
20~29	72.9	1.4	69.7	5.0
30~39	74.2	1.2	68.7	3.5
40~49	68.7	5.8	67.4	6.2
50~59	62.8	11.9	63.4	6.4

Source: Nam et al., 1995 *National Health Behavior Survey*, p.300.

Table 24. Comparison of Smoking Rate of Adult
Aged 15 or Over between Countries
(Unit: %)

	Korea (1995)	Japan (1990)	U.S.A (1992)	U.K (1992)	Germany (1992)	France (1992)
Male	61.0	59.8	28.6	29.0	36.8	38.0
Female	5.6	13.8	24.6	28.0	21.5	20.0

Sources: 1) Nam et al., *1995 National Health Behavior Survey*, p.66.
2) OECD, OECD Health-Data(CREDES/OECD), 1995.

Alcohol Consumption

Gender differences were also significant in the area of alcohol consumption, with 13.5% of adult women and 50.8% of adult men reporting that they enjoy drinking. In terms of the frequency of consumption, 12.6% of all male respondents(24.1% of male drinkers) and 1.0% of adult female respondents (8.5% of female drinkers) claimed to drink almost everyday(see Table 25).

Table 25. Frequency of Alcohol Consumption by Sex
(Unit: %)

	Drinking Population	Once or less/month	2-4times /month	2-4times /week	Almost Daily	Never Drinking
Total	31.4	2.2	11.4	11.2	6.6	68.6
Male	50.8	2.2	16.2	19.8	12.6	49.2
Female	13.5	2.2	7.0	3.3	1.0	86.5

Source: Nam et al., *1995 National Health Behavior Survey*, p.300.

Table 26. Percentage of Alcohol Consumption by Age
(Unit: days)

	Total	15~19	20~29	30~39	40~49	50~59	60~69
Total	31.4	9.6	39.3	36.5	35.2	27.9	23.7
Male	50.8	14.1	54.2	58.7	60.1	51.6	44.9
Female	13.5	5.6	26.4	14.8	9.6	6.0	8.0

Source: Nam et al., 1995 *National Health Behavior Survey*, p.86.

The percentage of adults who said they drove after drinking more than once during the last one month was 19.2%. There are also big gender differences; 22.4% of males and only 3.2% of females said they have had an experience of drinking and driving.

Table 27. Frequency of Driving Experience After Drinking
(Unit: %)

	Total	Never	Once/month	2~3 times /month	4~5 times /month	6 times or more
Total	100.0	80.8	7.8	7.3	1.8	2.3
Male	100.0	77.6	0.9	8.7	0.2	2.6
Female	100.0	96.8	1.8	0.3	0.4	0.8

Source: Nam et al., 1995 *National Health Behavior Survey*, p.249.

Men tend to smoke and drink more than women, and these behaviors markedly increase the risks of some chronic disease. The gender differences in smoking and drinking, however, are decreasing among

the younger generation. Therefore, with the increasing labor force participation of women, these behavioral changes can reduce gender differences in mortality and life expectancy.

Eating Patterns

Emerging nutritional problems are life-style related issues, such as obesity and an unbalanced food intake. These problems are related to quality and taste rather than quantity.

Over the past six years since 1989, eating patterns have changed unfavorably. The rates of skipping breakfast increased from 26.0% to 34.6%; the rates of irregular eating increased from 35.2% to 47.6%; and the rates of snacking between meals increased from 45.6% to 77.5%.

The rate of those who said they skip breakfast was higher among women than men. A gender difference was also found concerning irregular eating patterns. The rate of those who eat irregularly was higher for females than for males.

Table 28. Trend of Skipping Breakfast by Sex
(Unit: %)

	1989	1992	1995
Total	26.0	28.1	34.6
Male	23.1	24.0	31.1
Female	28.7	31.7	37.9

Source: Nam et al., *1995 National Health Behavior Survey*, p.303

Table 29. Trend of Irregular Eating by Sex
(Unit: %)

	1989	1992	1995
Total	35.2	39.3	47.6
Male	31.8	32.7	44.3
Female	38.3	45.1	50.8

Source: Nam et al., *1995 National Health Behavior Survey*, p.303

Exercise

According to the '95 National Health Behavior Survey, women are exercising less. Among women 15 to 69 years of age, 68.0% reported that they did not perform any exercise at all, compared to 48.9% among male respondents. Furthermore, 16.9% of women said they get regular exercise while 32.0% of men did.

Table 30. Frequency of Exercise

(Unit: %)

	Total	Never	Often	Once /week	2~3 times /week	4~5 times /week	Almost Daily
Total	100.0	58.8	17.1	6.9	8.0	3.6	5.6
Male	100.0	48.9	19.2	9.0	10.6	4.6	7.8
Female	100.0	68.0	15.2	5.0	5.6	2.8	3.5

Source: Nam et al., *1995 National Health Behavior Survey*, p.198.

Weight Control

Fifty seven percent of all respondents classified their body weight as average, while 24.3% of them said they were overweight and 18.7% claimed to be underweight. Significant gender differences appeared in self-assessed body weight. Specially, 32.5% of adult women reported that their body weight could be classified as overweight while only 15.5% of men did (see Table 31).

More women than men practiced weight control, and females in the younger age group practiced weight control the most(see Table 32).

Table 31. Self Assessed Weight by Age

(Unit: %)

	Total	Underweight	Desirable	Overweight
Total	100.0	18.7	57.0	24.3
Male	100.0	24.9	59.6	15.5
Female	100.0	12.9	54.6	32.5

Source: Nam et al., *1995 National Health Interview Survey*, p.196.

Table 32. Weight Control Practice Rate by Age
(Unit: %)

	Total	15~19	20~29	30~39	40~49	50~59	60~69
Total	25.2	31.8	32.7	26.0	22.8	18.9	10.0
Male	20.2	18.9	24.3	22.1	21.3	14.9	9.6
Female	29.9	43.3	40.0	29.7	24.3	22.7	10.4

Source: Nam et al., 1995 *National Health Interview Survey*, p.197.

Preventive Care

Thirty six percent of adults 20 to 59 years of age reported that they had received a health examination within the past year, up from 22.5% in 1989. Women received less preventive care than men.

Most cancer screening services are provided at private clinics. In the case of cervix cancer, 19.6% of adult female respondents had had a screening within the past year, which is low compared to 75% in the U.S.A.⁴⁾.

4) U.S., DHHS, 1990, *Healthy People to 2,000 -National Health Promotion and Diseases Prevention Objective-*, p.420.

Table 33. Health Examination Rate by Age and Sex
(Unit: %)

	Total	15~19	20~29	30~39	40~49	50~59	60~69
Total	36.1	39.4	31.9	34.5	42.7	38.1	29.7
Male	41.8	39.5	33.7	43.8	49.2	46.1	34.3
Female	30.9	39.3	30.3	25.4	35.9	30.8	26.2

Source: Nam et al., *1995 National Health Interview Survey*, p.235.

Table 34. Cancer Screening by Type of Cancer
(Unit: %)

	Stomach	Liver	Lung	Intestine	Breast	Cervix	AIDS
Total	7.0	6.8	5.1	4.0	6.1	19.6	3.8
Male	8.9	9.9	7.2	5.2	-	-	5.0
Female	5.2	3.9	3.3	3.0	6.1	19.6	2.7

Source: Nam et al., *1995 National Health Interview Survey*, p.237.

Medical Service Utilization

The proportion of the population that had contact with a physician at least once in the past year was higher for women than for men. Among all the surveyed respondents, 55.9% of the women said they visit hospitals or clinics more than once a year while 48.4% of the men said the same(see Table 35).

Based on the data, we can conclude that women tend to utilize medical services more frequently than men. Usually, women have a greater willingness to utilize medical services because they have learned

helplessness during their whole life. Moreover, being sick and taking care of one's illness is more socially acceptable for women(Nathanson, 1975; Verbrugge, 1985).

Table 35. Number of Physician Contacts per Year
(Unit: %)

	Total	None	1	2~20	21 or more
Total	100.0	47.7	11.4	37.3	3.6
Male	100.0	51.6	12.1	33.2	3.1
Female	100.0	44.1	10.8	41.1	4.1

Source: Nam et al., *1995 National Health Interview Survey* p.186.

In addition to their greater willingness, women also have more ability to take action. Women tend to have more flexibility in arranging their time schedules and incur fewer costs for taking time off for curative actions. Their schedules are more flexible and can be changed to accomodate health problems(Nathanson, 1975; Verbrugge, 1985).

Table 36. Percent Distribution of Hospital Episodes during the Year Preceding Interview for all Causes and Excluding Deliveries (Unit: %)

	All causes				Excluding Deliveries			
	Number of Episodes				Number of Episodes			
	Total	None	1	2 or more	Total	None	1	2 or more
Total	100.0	94.8	4.9	0.3	100.0	95.9	3.8	0.3
Male	100.0	95.7	4.0	0.3	100.0	95.7	4.0	0.3
Female	100.0	93.9	5.7	0.3	100.0	96.2	3.5	0.3

Source: Nam et al., *1995 National Health Interview Survey*, p.242.

Although hospitalization rates for all causes is slightly higher for women, hospital admission rates excluding deliveries are lower for women than men. Also, women stay in the hospital for a shorter period of time compared to men; the average length of stay is 18.2 days for men and 10.5 days for women (Kim, 1994; Song, 1993).

Table 37. Average Length of Hospital Stay during the Year Preceding Interview for all Causes and Excluding Deliveries per 100 Persons by Type of Hospitals

(Unit: day)

	All causes				Excluding Deliveries			
	Length of Hospital Stay				Length of Hospital Stay			
	Hospital for the Tertiary Care	Hospital for the Secondary Care	Hospital for the primary care	Clinic	Hospital for the Tertiary Care	Hospital for the Secondary Care	Hospital for the primary care	Clinic
Total	21.83	28.42	19.53	18.09	20.99	26.80	18.77	15.88
Male	23.59	33.66	24.68	23.05	23.59	33.66	24.68	23.05
Female	20.19	23.51	14.71	13.44	18.56	20.37	13.23	9.16

Source: Nam et al., 1995 *National Health Interview Survey*, p.255.

In conclusion, in spite of higher morbidity and more frequent visits to doctors by women, hospital admission rates are lower. Therefore, it is reasonable to assume that a substantial number of women's health needs are not being met.

Chapter 4

Medical, Demographic, and Socio-cultural Environment

Gender refers to the cultural, social, and political construction of men and women. In other words, biological factors are not the only components impacting on women's health. The medical, demographic, and socio-cultural environment also have an important influence on women's health.

Women's Participation in Medical Area

When women within the health care system can work under better conditions and have much greater power and authority, effective and humane medical services can be given to women. The number of female health providers who have similar life experiences is small in the medical profession and even fewer women have decision-making positions.

Women comprise 65.2% of the total number of licensed medical personnels(see Table 38). However, the proportion of women among the core medical personnel, such as physicians, dentists, and oriental physicians, is relatively low. Women make up 17.6%, 19%, 7.8% of physicians, dentists, oriental medical

doctors respectively. On the other hand, 57.6% of the pharmacists and almost all the nurses are women. The lower percentage of women in decision making position results from the lower percentage of female students in medicine, oriental medicine and dentistry (see Table 39). Therefore, policies to increase women's participation in the health area are needed.

Because medicine alone cannot guarantee the optimization of women's health, women also need access to the basic resources necessary for meeting their own health needs and those of their families. However, women's level of participation in politics and decision-making is very low. Currently, there are only 9 female legislators and only 1 female cabinet member, which is 3% and 5% of the total number of legislators and cabinet members respectively.

Table 38. Number of Medical Personnels Licensed by Sex (1994)

(Unit: person, %)

Kinds	Total(A)	Male	Female(B)	A/B
Physicians	54,406	44,804(55.6)	9,602(6.3)	17.6
Dentists	12,939	10,486(13.0)	2,453(1.6)	19.0
Oriental Medical Doctors	8,179	7,537(9.3)	642(0.4)	7.8
Pharmacists	42,037	17,823(22.1)	24,214(16.0)	57.6
Nurses	114,320	-	114,320(75.6)	100.0
Total	231,881(100.0)	80,650(100.0)	151,231(100.0)	65.2

Source: Ministry of Health and Welfare, *Yearbook of Health and Welfare Statistics*, 1995, pp.101~102.

Table 39. Distribution of Majors in University by Sex

(Unit: person, %)

	Total Number	Female	% of Female
Medicine	19,328	4,293	22.2
Dentistry	4,789	1,446	30.2
Oriental Medicine	4,797	813	16.9
Pharmacy	5,473	3,697	67.5
Nursing	5,963	5,943	99.7
Other Health Related Majors	5,251	2,396	45.6
Total	45,601	18,588	40.8

Source: Ministry of Education, *Statistical Yearbook of Education*, 1996, pp. 694~697.

Population Aging

Due to the rapid decrease in the fertility rate and the substantial increases in life expectancy, the population is aging at a fast pace. Population aging produces many social problems. In particular, aging results in many difficulties for women. The majority of the elderly are women. The sex ratio(males per 100 females) of the total population was 101.4 in 1995. The sex ratio of the population groups aged 60 and over, 65 and over, and 70 and over were 67.4, 59.4, and 53.6 in 1995 respectively.

Women live about eight year longer than men. In addition, women generally marry men who are 3~7 years older. Therefore, the majority of elderly women are living without their husbands. Regarding the marital status of those aged 60 years and over, 50.3% were married in 1970, 53.0% in 1980, and 54.9% in 1990, showing a constantly increasing trend. Among the same age group, 87.7% of the males and only 36.8% of the females lived with spouses(see Table 40). Because women are economically dependent on their husbands through their life course, elderly women without spouses have severe economic problems (Rhee et al, 1994).

In addition to economic problems, more elderly women have multiple chronic diseases than elderly men(see Table 41). Furthermore, the majority of the population who live in welfare facilities for the

elderly because they have no family members to take care are women. In 1993, 73% of the elderly living in welfare facilities for the elderly were female. These facts indicate that elderly women suffer from economic and health problems.

Though there are no specialized health services for elderly women, the improvement of the health service system at the governmental level can enhance the health conditions of elderly women by increasing the qualified health and medical manpower for the care of the elderly. It is also necessary to reduce the burden of medical costs for the elderly in the National Medical Insurance system.

Table 40. Sex ratio and Marital status of Elderly population
(Unit: %)

	1970	1980	1990	1995
Sex ratio				
Total pop.	100.8	100.5	100.7	101.4
60 and over	69.8	67.3	64.8	67.4
65 and over	62.1	59.5	60.0	59.4
70 and over	55.8	51.0	52.6	53.6
Marital status				
60 and over	50.3	53.0	54.9	57.2(Male:87.7, Female:36.8)
65 and over	41.6	45.0	47.2	47.7(Male:83.7, Female:26.5)
70 and over	33.5	36.1	38.6	39.5(Male:78.7, Female:18.4)

Source: 1) Economic Planning Board, *Population and Housing Census Report*, 1960~1985.
 2) National Statistical Office, *Population and Housing Census Report*, 1990.
 3) National Statistics Office, *Population Projection for 1990~2021*, 1991.
 4) National Statistical Office, *Advanced Report of 1995 Population and Housing Census*, 1996.

Table 41. Number of Chronic Diseases by Sex
(Unit: %)

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

Source: Rhee et al., *Living State and Its Policy Implications of the Korean Elderly*, 1994.

Safety at Workplace

General Work Place Safety

Based on the Korean Industrial Safety Corporation Law, the Korean Industrial Safety Corporation headquarters and four affiliated organizations such as the Industrial Safety Research Institute, Industrial Health Research Institute, Industrial Training Institute, and Branch Offices were established. In addition to that, Korean Industrial Health Association(KIHA) was founded in 1963. Seven committees of KIHA address the following issues: compensation for industrial accidents, phenumoconiosis, health management, academic activity, occupational diseases, environmental health, and education and training. However, health in general, and women's health in particular, have had a low priority and this is likely to continue as the current economic climate puts jobs and wages at risk.

Safety at the Office Workplace

In Korea, the majority of employed women are working in clerical and secretarial work. Most of the health hazards of office work are related to Repetitive Strain Injury(RSI), which was first reported as a "syndrome" among clerical and other workers and is just beginning to be recognized as a medical problem. For the adequate and effective care for these health hazards, efforts should be made to get the problem recognized, using existing medical research as well as first-hand testimony collected from thousands of workers.

Women's experiences in office work have also been important in highlighting sexual harassment as a public health issue. Recently Korean women have begun drawing up of guidelines for the identification of harassment and the punishment of offenders.

Prostitution

It is impossible to accurately determine the current number of prostitutes. However, it is estimated that the number of prostitutes is gradually on the increase, and new kinds of prostitution have appeared, such as hostesses, call girls, shaving girls, and massage girls.

Women are not only drawn into prostitution with dreams of escaping poverty, but also lured by promises

of honest employment, good-pay, and benefits by recruiters. In some cases, middle and high school drop-outs (most of them under the age of 18) had jobs as waitresses of pub houses, but turned to prostitution in the end. According to the survey of prostitutes (KWDI, 1993), almost all prostitutes have run away from home. Typically, they end up as prostitutes through the other jobs after running away. The leading reason for becoming a prostitute is "to earn money," the second is "lured by others", and the third is "curiosity." The main obstacles prohibiting prostitutes from reintegrating to society can be summarized as economic factors, social stigma, and internalized characteristics through prostitution.

As of 1994, there were 122 Women's Counselling Centers providing counselling services to these women. There are 23 vocational guidance centers providing prostitutes with vocational training and education for their social reintegration (MOHW, 1995). These are insufficient to provide adequate services to prostitutes, and more experts are needed to counsel these women.

The Prostitution Prevention Act was enacted in 1961 and is still in effect. Recently the Act was amended to punish both the act of selling and buying sex. However, administrative actions have been incapable of reducing the acts of encouraging and exploiting prostitution. Strong administrative actions to reduce prostitution and the establishment of counselling

centers and safeguard facilities are urgently needed. Fundamental changes will only be possible, however, when dual norms about sexual behavior disappear in Korea.

Freedom from Violence

Domestic Violence

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

Under the current laws, abusers committing serious battering are subject to the "Act of Violence and Punishment," but as yet no provisions have been made to issue protective orders in order to keep alleged abusers away from their victims(KIC, 1992).

Service agencies are limited. Thirteen privately-funded shelters and only two government-funded shelters for battered women have been built. There are a few legal and medical assistance programs, but

no domestic violence prevention programs. Several studies(Hu, 1993; KIC, 1992; KWDI, 1993) have found that half of all married women have been the victims of violence at the hands of their husbands. Incidents of violence occurred within the first year of over half of the marriages and 20% of wives were battered more than once a week. Battered wives were found to be troubled by physical, emotional, and psychological pains. The most common physical symptoms are severe headaches, bruise, and broken bones. Most battered wives lose their trust in others and avoid social gatherings. Unfortunately, the violence is passed on to succeeding generations.

As well as providing services for abuse survivors, women's organizations have also been involved in campaigns to change those aspects of their social environment that continue to promote violence. Therapy programs have to be developed for persistent batterers, and community education strategies are necessary to reach a wider population of both actually and potentially violent men, as well as those who could help to control them. Currently, the National Assembly is preparing a law to punish domestic violence offenders and protect victims.

Rape and Incest

The public's awareness of the problems of rape and incest is low, and some Koreans still blame the

victims of rape and incest for these crimes. Few cases of rape and incest are reported, and very seldom are suspects actually indicted in those reported cases. According to statistics collected in 1992, 38 women per 100,000 women were raped. However, it is estimated that only 2.2% of all rape victims report the incident. According to police records, the rape rates in Korea are the third highest in the world (just after America and Sweden). Taking into consideration the low rate at which these cases are reported, it is estimated that approximately 200,000 women a year are raped (KWDI, 1995).

There are no national statistics on health consequences of rape and incest, but several studies report that the victims of rape and incest suffer from the psychological effects throughout their entire lives. Of those raped, 89.5% exhibited emotional disturbances, 80.2% reported physical symptoms, and 77.1% reported maladjustment in their family life (KWDI, 1992).

There are no government-funded shelters for sexually abused women, and only a few privately-funded battered women's shelters provide services to help women cope with the traumas of sexual abuse. Furthermore, because victims tend to keep their experiences a secret, most women do not receive the appropriate psychological treatment, and thus the psychological consequences become even stronger and deeper (KIC, 1989; Park, 1994). "Special Law for Sexual Violence" was implemented in 1994, resulting from

active campaigning by the women's organizations in Korea to eradicate sexual violence. Counselor-training programs for sexually abused women have been developed recently.

Chapter 5

Policy Recommendations for the Improvement of Women's Health

Considering the rapid economic development in Korea, social support for the advancement of women's health is low. The World Health Organization established the health policy goal of "Health for All by the Year 2000". It is necessary to put a primary focus on women in order to achieve this goal, because women's health means health for next generation and illness means socio-economic loss. The guidelines promote the development of women's full capacities as a way to add to human resources and to lead healthier family lives.

Improving women's health status requires changes in both the attitudes toward and the structure of health care, because women's health problems mainly are attributed to social discrimination toward women's sex-roles and health care, which has been oriented toward men. To improve women's health, the following steps should be taken into consideration.

Establishment of Information System on Women's Health

A lack of adequate gender-specific, gender-sensitive and gender-disaggregated data and research continues to be a barrier to developing appropriate policies for women's health. It is necessary to gather gender-disaggregated, gender-specific, and gender-sensitive data on the health of women to formulate and implement gender-balanced health policies. All information related to health problems should be classified by sex since there are differences between men and women in health-related experience. For this research on women's health care, such as preventive health, public health service, and biological and social factors should be promoted. The distribution of information through the media is also important.

Strengthening Preventive Reproductive Health Policies

A women's status is inextricably linked to her reproductive role, and it affects her health to a very large extent. Control of women's fertility requires not only better methods of fertility regulation and health delivery systems, but also more substantial improvements in women's health.

First of all, health care services to prevent and

cure the health problems related to reproduction have to be strengthened. For this, prenatal care and postnatal care should be covered by health insurance.

Secondly, preventive health programs to reduce ill-health resulting from abortions have to be strengthened. Though contraception is widely practiced, the rate of induced abortions is very high among both married and unmarried women. Indeed, the government should include abortions and post-abortion services as an integral part of health services.

Third, there is a high cesarean section rate in Korea which stems from the fact that medical institutions can make more money if they perform cesarean sections. In order to prohibit unjustifiable cesarean sections, the government should minimize the gap between the cost of cesarean sections and vaginal delivery.

Fourth, considering the distortions in the sex-ratios at birth, social support to reduce the sex-selective abortions is urgently needed. The government should institute policies to eliminate this and, at the same time, promote and enhance women's status. As a first step, the government should strengthen the prohibition and penalties of prenatal sex identification procedures for the purpose of sex selective abortion. The government has already taken action to forbid prenatal sex identification by revising the medical laws in 1987 and 1994, which led to strengthening of

the disciplinary code. Physicians who provide such medical services for identifying prenatal sex can be punished with imprisonment or a substantial fine, and can have their medical licences cancelled. However, these legislative measures do not appear sufficient to eliminate sex-selective abortions.

Therefore, in addition to that, institutional and social support policies to weaken the high value of sons should be implemented. In particular, Korea has to reform its patriarchal family laws and traditional customs which hinder the achievement of equality of the sexes. The general improvement of women's status can be the best way to reduce the abortions resulting from the prenatal sex selection.

Policies to Improve Health Behaviors for Women

Unhealthy behaviors were prevalent among the general population, but they were more serious among women in the areas of eating habits, exercise and weight control. These findings demonstrate the need to improve strategies for educating women and motivating them to incorporate healthy behaviors in their lives. The health promotion and health education programs should be focused on women to decrease behavioral risks and to foster social and environmental changes that facilitate these behavioral changes.

These efforts will markedly improve the health and well-being of women in Korea.

Policies to increase Women's Participation in Health Area

Women's involvement in the decision making process of health policy is essential to ensure a gender-sensitive perspective in health care policies. As women have been excluded from top positions and important roles, temporarily they have to be given priority to assume an important and expanded role with authority in the primary health care system and given support to develop their competence. For this purpose, a large percentage of female personnel should be given spots on health service and health policy committees. Furthermore, through education and training, provision of skills and information, and networking women's organizations the development of women's ability to resume important roles in the health area is required.

Policies to Protect Women from Violence

Violence to women, especially domestic violence and rape, are prevalent in Korea. For the protection of women from violence, the Korean government has to

implement two kinds of efforts. The first is a legislative effort to regard domestic violence as a public affair and to punish the batterers as criminals. The other is the effort to support the victims of domestic violence and rape.

First of all an act related to the punishment of domestic violence offenders and the protection of victims has to be enacted. Moreover, the current "Special Law for Sexual Violence" has to be revised. The provision that, in order for a sex-offender to be prosecuted by the law, he has to be accused personally has to be abolished. In addition, sexual harassment at the office or workplace has to be designated as a crime under the "Special Law for Sexual Violence."

At the same time, the government has to establish shelters for sexually abused women and battered women and funds for the privately-funded shelters in order to give sufficient service for the victims. At least one shelter at the city or county level should be established in the near future. Furthermore, it is urgent that the social environment which promote violence be changed through consciousness-raising education on non-violence.

Chapter 6

Conclusion

For the introduction of gender-balanced health policies in Korea, this paper reviewed women's health status, health behavior, and medical utilization, and it evaluated the current social environment impacting women's health. The main findings are as the follows: although family planning practice rates are high, female contraceptive measure are frequently employed and induced abortion rates are high; although women have higher rates in terms of both physical and mental morbidity and more frequently visit physicians than men, they are hospitalized less frequently compared to men; although women smoke and drink less, they tend to skip breakfast and eat irregularly more frequently than men; few women have decision-making positions in the medical area; and finally, social support to protect women from violence is not sufficient.

To solve these problems related to women's health, several policy recommendations are suggested. The government has to strengthen preventive reproductive health policies and health education for the promotion of healthy behaviors; legal efforts to protect women from violence should be made; as a

part of the policy to increase women's social participation, the policies to increase women's involvement in the decision-making process of health policy formation are urgently needed. For the successful implementation of above-mentioned policies, the establishment of an information system on women's health based on the cooperation of the government, women's organization, and scholars is essential.

Because women's health is largely determined by socio-cultural factors, the general enhancement of women's status can significantly improve women's health. Improving women's status should be the primary concern in discussions of how to enhance women's health. The most important task, therefore, is to target all discrimination against women. In accordance with the President's Special Commission on the Globalization of Korea, Ten Policy Priorities for the Advancement of Korean Women have been set up. Hearing that the Korean government is taking positive steps to enhance women's status at both the public and private levels is welcome news.

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