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Family Planning Programs During Last One Decade in Korea

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A. An Overview of the Population Crisis in Korea

In addition to three million refugees from North Korea by the close of the Korean War in 1953, there was a post-war "baby-boom" since that. The 25 million population in 1960 increased by 3% per year. Korea's total land area is 34,427 square miles. Only one-fifth of her land area is arable. This meant every square miles of cultivated land had to support 3,200 persons in 1960.

Year	1960	1970
Estimated Population	25,000,000	32,000,000
Density per Sq. Km	254	325
Urban Population: Rural Population	28 : 72	40 : 60
Nonfarm Population:Farm Population	43 : 57	54 : 46
Density per Arable Land (Sq. Km)	1,350	1,520
Estimated Birth per 1,000 Population	42	28
Estimated Death per 1,000 Population	12	8
Rate of Natural Increase (percent)	3.0	2.0
GNP per Capita (US $)	94	223

The People's expectation for better nutrition, health, education and shelter endlessly escalated, while the government with the GNP per capita of 94, had to struggle for the national economic development and defense against future invasion.

B. Approaches Taken to Meet the Crisis

1. *Voluntary Organization:*

Stimulated by the visit of Mr. & Mrs George W. Cadbry in late 1960, the voluntary leaders interested in promotion of health and welfare of the people and national development got together to formulate a national voluntary organization, The Planned Parenthood Federation of Korea(PPFK), for a nation-wide family planning movement.

The group fully acknowledged the problems of rapid population growth and the future responsibility of the government, though they had a strong faith that the ultimate goal is for the health, happiness and wellbeing of the individual family. Therefore the policy was to enlighten and

educate the people for family planning and not to force it on them.

This is why the PPFK is not a competitor but a strong supporter of the government program, and we have close cooperation each other, with the maintenance of our own unique roles.

2. *National Family Planning Programs:*

a. Objectives: Limiting population increase through the family planning program is an integral part of Korea's economic development plan. The objectives of the family planning programs according the ten year plan formulated by the Ministry of Health and Social Affairs is to reduce the natural increase rate of 3 percent in 1961 to 2.5 percent, 2 percent and 1.5 percent by the end of 1966, 1971 and 1976 respectively.

b. Activities or Projects: In order to achieve the initial ten-year goal by 1971, it is estimated that 45 percent of the married couples of childbearing age must actively practice family planning, 35 precent through the government program and 10 percent through their own resources. It was estimated that less than 5 percent of eligible couples were practicing family limitation prior to 1961.

Implementation of the program is dependent on 2,370 fulltime family planning workers dispersed throughout the country (one worker per 1,250 eligible couples in rural areas and 1 per 2,980 in the cities). The PPFK has been responsible, by and large, for the training of these field workers. Annual targets for IUD, oral pills, vasectomy, and condom users are allocated to each area mostly in accordance with the population. Workers recruit eligible couples to accept one of the methods offered by the program through door-to-door visits and group meeting. In order to assist the workers, the PPFK organized mothers' clubs in 16,868 administrative villages throughout the country in 1968. Extensive information and education services through printing materials and radio, television are provided by PPFK with collaboration of related agencies.

The field workers themselves distribute condoms and oral pills and refer IUD and vasectomy acceptors to private physicians trained and authorized by the government (1,000 doctors for IUD, 600 doctors for vasectomy). These physicians provide the services at their own facilities and are reimbursed through the program on a per case bases. These services except for oral pill (10¢ per cycle) are free to the acceptor, and each vasectomy acceptor receives $3.00 compensation for work time lost. Acceptors experiencing medical complications as a result of one of the methods can obtain treatment free.

Contraceptive methods offered by the program on "cafeteria choice" were foam tablets, condom, jelly, and rhythm methods till 1964 when IUD was introduced as the primary methods after one years clinical trial. From 1967 oral pills were provided for those who could not tolerate IUD, but from 1969 were offered to all womens. A male sterilization program was added from late 1963. Currently IUD, oral pill, condom and vasectomy are the leading methods accepted in priority order.

Although illegal, abortions are performed by numerous physicians with very little interfercnce from the Government. A 1967 KAP survey showed that 25% of urban women and 7% of rural women had experienced at least one induced abortion. A 1968

fertility survey showed the experience rate at 30% in urban areas and 15% in rural areas, a sharp rise among rural women over the 1967 figures.

In 1964 the first KAP study was conducted by a joint effort of Yonsei University and PPFK. They were succeeded by the Family Planning Evaluation Unit of the Ministry of Health and Social Affairs from the following year. Numerous studies and surveys have also been conducted at universities and colleges. The PPFK has been responsible for the support and arrangement of clinical trial with any new contraceptive method before the government's approval for importation or production.

c. Scope of Coverage: The national family planning program operates through the Family Planning Section of the Bureau of Public Health, one of five bureaus in the Ministry of Health and Social Affairs. The chief of the Family Planning Section handles the day-to-day management of the program in close consultation with the Bureau Director. These officials carry direct responsibility for policy, budgets and targets, supplies, records, and relations with the provinces. The Ministry of Health and Social Affairs works with the Ministry of Home Affairs, which oversees provincial and local government. This Ministry acts through the nine provincial governments and two special city governments, all of which have Family Planning Sub-sections in their Bureaus of Public Health and Social Affairs. All targets for acceptors of contraceptive methods given to the provinces are passed on to the counties, then to the townships, and finally to the field workers.

The actual services have been implemented through the already existing national and provincial health service network, which consists of 191 health centers, located one per county (139) in rural areas and one per city ward (52) in urban areas. From the beginning this organization provided an automatic network for routine administration, a channel for reporting, and a definite chain of command from the national to the local level. This enabled the program to get off to a fast start, and avoided the necessity of constructing a large, new organization.

C. Problems Met in Implementing Family Planning Programs

1. *Administrative Problems:*

a. Financing has been a serious problem since 1967. The original 1971 budget of the Ministry of Health of about 700 million won (equivalent of US 7¢ per person) was cut to 486 million won.

The intent is apparently to protest to the EPB about the too small health budget, only one percent of the total national budget. The first half of the year, which is the most productive part of the year, is always wasted by the staff in the central government to restore the money in supplemental budgets, and by the field workers suspending full effort till July, when they get new instructions with revised full targets and the budget for the year.

b. Taking account of the importance of the program, the administrations of the program must be vested in at least a bureau level governmental organization. This is essential to have a well qualified staff with high caliber and authority to supervise the program and negotiate with related agencies. There is much room to improve systemic coordination and cooperation with other government ministries such

as Eductation, Public Information, Agriculture, Commerce and Industry, National Defense, Parliament, and private agencies.

c. The program has been almost totally related to health centers and doctors in private practice: The hospital network has been involved only sporadically. Health Center personnel are responsible to their county chief administrator but neither to the Provincial Health Department nor to the Ministry of Health. This makes supervision of field activities difficult. There is no adequate systematic supervisory system developed as yet.

d. By and large the health service in Korea is poor. Maternal and child health service is in its infantile stage still. We know that MCH service is not as cheap nor simple to develop as contracepive service. Therefore premature integration of family planning into maternal and child health and other services is likely to weaken already well established family planning services.

e. The target system, which emphasizes the initial acceptance of a method and quantity more than quality of service, has not emphasized follow-up by field workers. There is a need for more contact with women by field workers, to lower the rate of discontinuation of contraceptive protection.

f. Vital statistics in Korea are very poor. This provides difficulty not only in evaluation of the program but also in planning of adequate targets and location of acceptors in their early postpartum period.

g. In order to meet the auditing requirement of government bureaucracy acceptors are requested to bring their "dojang"-signature chop, and identification card at each time of getting supplies and services. The field workers have to carry dojang ink and have to spend time to issue a receipt of 10¢ per cycle of pills individually.

2. *Professional Workers Problem:*

a. The rate of attrition of trained field family planning workers is too high. By the end of two years more than two-thirds of trained field workers are leaving their jobs. Though the vacancy rate of field workers' positions is not too high (5.6% as of October 1, 1970), almost 50% of those currently on the job have less than one year's experience. The vacancy rate of health center level family planning nurses is not only very high(19.6% in October 1, 1970) but also replacement by unqualified women workers causes only 22.3% of health center family planning workers to be nurses. One reason is that the pay is too low. There is little future in the job, and the drain to West Germany and other well-to-do countries continues.

b. Health center director: the M.D. is no exception to the above mentioned problems. There are very few well qualified public health doctors in this position. Those who do take the position do not take a long time to becone discouraged with poor salary, little authority over their own staff personnel, and poor support from local authorities. Therefore most of health officers staying in his position long enough are generally poor in their professional ability though there are exceptions.

c. Those responsible for the administration of family planning programs of local governments (city, county, and province) are not experienced professional workers but they are lay male clerks assigned to the position by local authority. They have some administrative experience in how to

deal with red tape but little knowledge about the program, but in practice the family planning nurses and women workers are under their control. Most of them are disappointed by the position and try to move to another field in the government. Therefore training of them yields little return unless some measure is taken to keep them longer in their positions.

3. *Acceptors Problems:*

a. During the decade of the 1960s, the number of eligible couples 20-44 years old was about 4,000,000. But in the 1970s this number will increase to about 5.5 million because of those born during the post-Korean War baby boom. They will enter into the early reproductive age group during this decade. To meet this problem additional personnel and budget will be necessary but are hard to get.

b. The population of Korea is rapidly urbanizing. This urban population being heterogenous in its character is difficult to approach through home visiting and group meetings. In the slums the community does not enjoy modern mass media such as television. A series of KAP surveys conducted demonstrates that knowledge of family planning is higher in the rural than in the urban areas. This means that education and motivation programs must be stepped up for the urban people, as well as the provision of services. We can not assume that the urban people are taking care of their own needs, but must give them adequate help also.

c. In reducing the population growth rate to 2.0 a year, the completed family size has been reduced to about four children. To reduce the growth rate further will require the two child family and involve many cultural value problems that are most difficult to change. One of these is the desire for a male heir, so that the most common desire for ideal family size is two boys and one girl. With this kind of value very strong in the culture, is it possible to further bring the family size down? At present we know of no answer to this problem through normal means of education and motivation. Perhaps it will occur slowly through the modernization and urbanization process. This will take a long time and will mean that the population problem will be much longer in solution with resulting economic and social problems prolonged.

d. The present contraceptive technology, while much better than in the past, is still not appropriate for the average person with limited knowledge of modern medicine. Side effects are reacted to in a non-scientific way and the first thought is to get rid of the cause rather than to wait for a natural adjustment to occur. With doubts around and common rumors of side effects known by all, mass media reports of the controversy over the safety of the pill has increased the number of women who stop. Newspapers and others seem to always publicise the bad news more than the good in such matters, making it necessary for the public to be sophisticated to interpret these reports properly. This will take more years of education before such a level can be reached.

D. Meeting the Problems

1. Many experiiments have been tried, and those thought successfu are now a part of the program that has already been described. This would include the use of para-medical personnel for home visiting, the organization of mothers classes, and a number of mass media programs.

2. Budget problems may be solved through the cooperation of the Korean government with USAID by the distribution of counterpart funds. It is hoped that this will be a means of improving the quality and the quantity of the program if present efforts are successful.

3. The rapid turn-over in health personnel with qualifications as nurses or nurse-aides will continue as long as there are opportunities for overseas employment. Much of the program will have to learn how to recruit and use laymen with a lower level of training. Some of this has happened over the last few years, and training programs for these people are being improved.

4. The program limited to the health centers will soon be expanded to the hospitals. This is not a post-partum program in the traditional meaning of the word. Personnel will recruit and educate both men and women on the various services, both in-patient and out-patient. Further, Korean families come to take care of their relatives, so these visitors will also be included as persons to be reached with contraceptive services in the hospital.

5. Urban health centers are widely scattered in the population. It is necessary to bring services closer to the people through mobile vans and utilization of various clinics, such as industrial, MCH, etc. The natural organizations of the city, must be used for recruitment and information, such as womens clubs, labor unions, school parents groups, religious groups, etc.

6. So far the major education effort has been with the mothers. An effort will be made to educate the young husbands through the 2,500,000 young men organized in the Homeland Reserve Force. These persons have periodic meetings and it has been demonstrated that education of them will produce results of clinic visits by their wives.

7. In order to reduce the ideal family size, and to help the young realize the importance of population controls, the Ministry of Education is now drawing up a plan for insertion of appropriate materials in the textbooks of the elementary and high schools. There is a fair amount of materials already in the texts, but it tends to be rather random and of uneven quality. The present study will produce a better organized curriculum officially approved and a higher quality of materials in the textbooks.

8. To improve the governments handling of service functions like training and evaluation, a National Institute of Family Planning has been organized. This is an agency of the Ministry of Health and Social Affairs to assist the Ministry in certain service functions. The main program remains under the control of the Family Planning Section in the Ministry. It is hoped that there will be an increase in the qualtity and quantity of personnel training to produce better fieldworkers.

9. Professional education institutes, such as medical schools, nursing schools, social work schools, are continuing to improve and develop their curricular offerings in family planning. A number of conferences have been held to improve coordination and exchange ideas and materials.

E. Total Acceptors at Present

The total acceptors are shown on an attached table. It can be said that Korea ranks among the highest programs on a per capita basis for all of the four standard methods used, condom, IUD, vasectomy, and

pill.

The cost per acceptor in 1970 has been calculated as $3.50 from the national and local budgets of the Korean government. Direct aid to the program from donor groups raises the costs to about $4.50 per acceptor.

F. Recommendations

1. About the organization, I would like quote from the Summary and Conclusions of the Report of the Population Council's survey team in 1962 to Korea: "Family Planning has been made the responsibility, logically, of the Ministry of Health and Social Affairs..... The urgency and importance of population control demand a degree of autonomy and official recognition that can be achieved only by an administrative unit whose sole responsibility is the success of the family planning program. Such a family planning unit, while remaining closely allied with Maternal and Child Health and other functions of the Ministry of Health, should be able to transcend the limits of any one ministry and include informational and other services better performed by other agencies of government. The unit should be under the direction of a man of sufficient force and stature to obtain cooperation and action at a high level. An attempt to administer a new program of this inportance with existing staff will not be successful in the long run.

The central family planning unit should be supported by strong provincial units organized on comparable lines, though depending primarily on the provincial bureaus of Health and Social Affairs. It is important that close liaison be maintained between the central and provincial units; this could be effected by the appointment of at least two regional supervisors, who would make frequent visits to all provincial units.

The program would also be strengthened and broadened by the creation of a National Family Planning Board, which would meet two or three times yearly to consider and define general policies. Its membership would represent governmental agencies as well as associations and institutions outside government whose interests and activities have a bearing on population."

2. However don't take too long a time to set up an ideal organization. Korea could launch a national program without any specific unit in the government organization but by delegation to the voluntary organization for the first two years.

3. Personnel is the most important element for a successful program. Adequate budget and simple and effective contraceptive technology alone without efficient personnel would not make any program successful. We need one fulltime worker per every 1,500 eligible couples. Do not expect much from existing health personnel who has already many jobs to do. Well trained lay fulltime workers or full time paramedical personnel are generally much more productive than part-time professional workers.

4. A number of well-controlled clinical and field studies on methods should be undertaken. There is no simple methods satisfactory to everybody. Therefore provide three alternative choices at the minimum.

5. Peoples learn from trial and error. The same principle applies to a program administrator. Be cautious in planning, but be brave in your action. Do not be too much discouraged with a high termination rate. Those who terminated one method have a

much lower fertility rate than those who used no method ever.

Goals and Results of the Ten-Year Family Planning Plan

Methods	Ten-Years' ('62-'71) Target	9 Years' ('62-'70) Achicvement	Progress (%)
IUC Insertions	1,800,000	1,795,360	99.7
Vasectomy	150,000	146,172	97.4
Supply of Traditional Contraceptives	150,000	163,000	108.7
Oral Pill	350,000	276,000	78.9

Goals and Achievement of Family Planning

	I. U. D.				Oral Pill	
	Goal		Achievement		Goal	Achievement
	Year	Cumulative	Year	Cumulative		
1962	—	—				
1963	—	—	1,493	1,493		
1964	100,000	100,000	106,397	107,890		
1965	200,000	300,000	225,946	333,836		
1966	350,000	650,000	294,340	628,176		
1967	350,000	1,000,000	323,452	951,628		
1968	300,000	1,300,000	263,132	1,214,760	350,000	60,000
1969	300,000	1,600,000	285,500	1,500,260	350,000	169,000
1970	300,000	1,900,000	295,100	1,795,360	350,000	276,000

	Vasectomy				Contraceptive Supply Condom	
	Goal		Achievement		Goal	Achievement
	Year	Cumulative	Year	Cumulative	(Month)	(Month)
1962	3,000	3,000	3,413	3,143	50,000	59,352
1963	20,000	23,000	19,866	23,279	100,000	129,804
1964	27,000	50,000	26,256	49,535	150,000	156,301
1965	20,000	70,000	12,855	62,390	150,000	191,706
1966	20,000	90,000	15,374	77,764	150,000	161,863
1967	20,000	110,000	19,677	97,441	150,000	152,000
1968	20,000	130,000	15,953	113,394	150,000	133,000
1969	20,000	150,000	15,457	128,851	150,000	147,000
1970	20,000	170,000	17,321	146,172	150,000	163,000