**Report from the South Korean Civic Society   
on the right to sexual and reproductive health   
: Challenges and Possibilities during COVID-19**

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**Background**

While the right to sexual and reproductive health (SRH) is part of the right to health enshrined in article 12 of the International Covenant on Economic, Social, and Cultural Rights and one of a key priority theme for women's rights, South Korea does not have any laws or institutions to ensure the Sexual and Reproductive Health and Rights (SRHR) as agreed following the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents for their review conferences. Although South Korea is widely praised for its relatively successful response to the COVID-19 pandemic, we marginalized values like SRH that had not been protected nor recognized during the pandemic. Thus, as advocates for the people's health rights in South Korea, we report the status of SRH and its challenges during the COVID-19 pandemic.

**State measures that reproduce aggravated the gender inequality**

The Korean government has adopted three major measures in response to the crisis under the COVID-19 pandemic: economic stimulus, employment protection[[1]](#footnote-1), and social distancing. These measures are not direct measures to protect and fulfill the right to sexual and reproductive health, but they are the material basis for SRH in a commercialized healthcare system, which impacts SRHR of the people. We claim that the State measures in response to the COVID-19 crisis in South Korea did not take the structural inequalities of the society, which lead to deteriorating the rights, especially for the vulnerable.

**Emergency relief grant (stimulus check)**

The government provided cash benefits to alleviate the financial difficulties of households caused by the COVID-19 pandemic and encouraging household consumption to boost the domestic economy. This policy, seemingly a universal approach, has led to gendered inequality as most of the householders in Korean families are men (even when they are not breadwinners). Other family members, particularly women and children, did not have any authority to access the cash benefits for themselves while equally experiencing the loss of income opportunities due to the pandemic. As a result, some girls could not afford to buy their daily necessaries, which was publicized as ‘period poverty’ in recent days (Kyung-Hyang, May 31th, 2021). Although Local governments in Korea are now starting to adopt a policy to support sanitary consumables for low-income families, this program only targets only 6.5% of adolescent girls, which makes us anticipate that there will be a huge blind spot. In addition, this approach made it difficult for women and children who suffered domestic violence to report the violence and thus separate from the violent partners or parents. It was grateful for small mercies that the government provided the grant for victims of domestic violence who live in shelters by considering them as separate households. But this policy entailed serious problems, as the location of women living in a shelter was exposed to the perpetrator in the administrative process.

**Family care leave / the subsidy**

The Ministry of Employment and Labor (MEL) has implemented several measures to support employment security. However, these measures have not protected employees who need to care for their sexual and reproductive health from the crisis. For example, 46.3% of female employees went through more than one employment adjustment, such as leave or even recommended resignation due to COVID-19, of which 35-47% were preferentially pregnant or on their maternity leave (Kim W. 2021).

Family care leave (up to ten days a year) for workers in urgent need of childcare forms a part of the measures. In addition, the ministry has actively engaged in efforts to support their income, providing a temporary subsidy of 50,000 Korean won (about 45 US dollar) per worker taking family care leave during the pandemic (up to 20 and 10 days per couple in 2020 and 2021, respectively). On the one hand, the leave and subsidy are not allowed to employees themselves. Workers who need time off work to take care of family members infected COVID-19 or their children under the age of eight in their school closure or took small classes are only eligible for the leave and subsidy. In addition, precarious workers are difficult to use the leave and apply for the subsidy due to fear of job loss even though they are entitled/covered by the law.[[2]](#footnote-2) It is known that it leads to unmet healthcare needs among precarious workers, and it will also be the case with their sexual and reproductive healthcare. It is also noteworthy that the proportion of precarious workers is 45.0% female and 29.4% male workers in 2020(K-indicator, 2020).

**Social distancing and care deficits**

Strong social distancing measures lead to essential care deficits as well. In the very first phase of the pandemic, most ‘care’ services and programs were stopped under social distancing measures.

The home visiting program for maternal and early childhood, postpartum healthcare was not the exception. The government had shifted the responsibility for maternal healthcare on women while they experienced depression, anxieties, social isolation, and even domestic violation.

Other daycare services and schools are closed as well. Firstly, school closure has deteriorated access to sexual and reproductive healthcare, including providing relevant goods such as sanitary pads among girls who cannot afford them. Secondly, it would negatively affect sexual and reproductive health as aggravating women’s double burden on work and care. Women (89.2% for full-time homemakers, 32.7% for dual-income earners) are more likely to take care of their children than men (3% for single-income earners, 11% for dual-income earners). It caused women to exit from the labor force and be disempowered. According to the Korean Women’s Development Institute (2021), the time women quit their jobs seems to coincide with the government’s announcement of measures to strengthen social distancing. In March, 19.9% retired and April, August, and November each accounted for 11.4%.

Telecommuting and staying at home have isolated victims of domestic violence. While a strong social distancing policy is enforced, they cannot ‘escape’ from home and access means of reporting violence. Activist counseling victims of domestic violence said that women who delayed or gave up counseling because perpetrators (mostly their partners or parents) were at home together doing telecommuting. The government, however, has not given active efforts to protect them. Meanwhile, shelters for victims of domestic violence were forced to be closed immediately after the COVID-19 outbreak. The restriction of access was also the same for the medical facilities for the sexual violence victims, where they were bounded for the rules for the quarantine. As a result, some rape victims could not get the proper medical service to gather the evidence for the sex crime in time.

**Specific measures and their effect on SRH during the pandemic**

The South Korean government does not have any specific department accountable for the SRH. Thus policies related to SRH tend to be partial, provisional, and fragmented. Despite this condition, we tried to gather the measures related to the specific areas of SRH mentioned in Question 2.

1. **Access to legal abortion**

Irrelevant to the COVID-19 pandemic situation, Korean women do not have formal/protected access to safe abortion. On Apr 11th, 2019, the Constitutional Court of Korea ruled that criminal law punishing aspirational abortion is unconstitutional, violating women's human rights. However, for the next year and nine months, the government failed to draw up a revision. The criminal law on abortion was officially invalidated on January 01st, 2021, but law and policies for safe abortion access had not been adopted. The Ministry of Health and Welfare, which must be accountable for follow-up measures after the decriminalization of abortion, is focusing their resource on the pandemic response such as test, trace, and treatment. The decision and healthcare coverage of abortion services has not been made yet, and private clinics are asking the women to pay even higher prices, passing the cost of risk and uncertainty to those women in desperate need. This can make vulnerable women with economic difficulties due to COVID-19 even more threatened in safe access to abortion. Also, the drugs for medical abortion (mifepristone and misoprostol) are not approved by the Korean authorities, but many women are purchasing abortion pills through illegal channels. Women have often purchased unsafe abortion pills with unverified safety and efficacy through illegal channels (such as online). While the Korean government allowed exceptional telehealth prescription in response to the pandemic, women cannot access medical abortion, just like it has never been.

1. **Same-sex and sexual relations**

After the COVID-19 cluster outbreak in Itaewon district in May 2020, where several nightclubs and gay clubs are located, social discrimination against sexual minorities had intensified. Many of the club's visitors were a sexual minority group, and the media spread the news with provocative titles and contents. All the fake information and rumors were spread through SNS, and that information was expanded and reproduced indiscriminately, resulting in a social stigma. Some media indiscriminately exposed the club visitors' personal information, and those who visited the club hid to escape from criticism, discrimination, and hatred. Due to this event, health authorities had a rough time contacting the club's visitors and contractors. Fortunately, the Seoul metropolitan government promptly implemented the anonymous inspections system to ensure their anonymity and secure human rights in accordance with preventing the spread of COVID-19. Civil society criticized the media for not following the reporting ethics and blamed them on their way to report that eventually led to strengthen a social stigma and justify discrimination against sexual minorities. In addition, the advocate groups held several press conferences to call for legislation, the Anti-Discrimination Act.

1. **Consensual sex between adolescent of similar ages**

In South Korea, informative and accurate education on consensual sex between adolescents is absent in public education. However, as schools closed after COVID-19 and turned into online classes, adolescents are on their own to protect themselves from the hazardous online enviornment. The online transformation made a favorable condition for digital grooming and sexual harassment without proper precautionary measures. Moreover, adolescents suffered from reduced interaction with peer groups. This disconnection of human relationships would have been even fatal, especially in vulnerable groups such as runaway youths and youths living in a support home.

More problematically, the isolation during the pandemic may have exposed adolescents to more dangerous relationships. According to an investigation by the Seoul city government, online sex crimes against adolescents have increased during the pandemic (Newsis, October 06th, 2020). A survey showed that teenagers experienced physical, language, and sexual violence online more than doubled after COVID-19 (YTN, March 23th, 2021). However, no policy efforts have been made to address these issues actively.

1. **Sex work**

Sex workers working in the Red Light Districts (RLD) were one of the people who were exposed to COVID-19 without proper protection measures in Korea. Multiple cases of cluster infection occurred in RLD, and it was also one of the places where epidemiological investigation falls into difficulty. As a result, many local governments implemented executive orders to conduct compulsory diagnostic tests of sex workers. The sex workers had no choice but to comply with the mandatory COVID-19 testing or pay expensive fines. According to a survey done by a sex worker advocacy group ELOOM, women in sex work were threatened with their right to health even if they were suspected of infection due to social hatred and fear of stigma. Half of the respondents mentioned the difficulty of the COVID-19 situation as "the risk of infection due to the environment in which masks cannot be worn, and they cannot avoid contact with buyers." At the same time, 23.9% said it was challenging to get the COVID-19 test for fear of stigma due to tracing. Some local governments had been found to have threatened the sex workers that they would claim indemnity rights to women who have not gotten the COVID-19 testing.

1. **HIV transmission**

Since every public health center shifted its focus on COVID-19 testing, access to HIV/AIDS testing has been significantly decreased during the pandemic. Since 2015 people have taken a free anonymous HIV/AIDS testing at the public health center in Korea, but after the outbreak of COVID-19, most public centers stopped the service. The only one that provides free anonymous HIV/AIDS testing, run by ISHAP (Ivan Stop HIV/ADIS), is left in Seoul. There are two alternatives to the public health center and ISHAP, one is in-hospital testing, and the other is a self-diagnostic kit called OraQuick. But it requires a user fee for people who want to get the test.

1. **Gender-based Violence**

According to the Korean Sexual Violence Relief center, there had been increasing reports of sexual abuse related to the quarantine measures, such as sexual harassment of women for wearing masks and not wearing masks. People being isolated in their own houses, the Risk of Intimate Partner Violence is rising, but the public services for the victims had been

**Sexual and Reproductive healthcare situation**

To explain healthcare service accessibility during the pandemic, we have to explain a bit of the healthcare system in South Korea. While South Korea had adopted the Social Health Insurance Scheme, which mandates every healthcare facility in Korea to be regulated by the same reimbursement scheme, the ownership of these hospitals is primarily private. According to OECD statistics, although South Korea is one of the countries with the highest number of hospital beds per person in the world, the share of the public hospital is lowest among OECD countries (number of acute hospital beds per 1,000 populations and the number of public hospital beds per million populations in 2018 is 35.1, and 4.3 each). This means only 12.4% of hospital beds are public (OECD Statistics, 2018). This means that every hospital is run by private actors, and despite its legally non-profit status, hospitals in Korea operate as a market actor, which relies on the profit they earned from the fee-for-service-based reimbursement system.

**Public health facilities mobilized for COVID-19 response – decreased healthcare access**

This context making (and justifying) Korean hospitals avoid treating COVID-19 patients. While almost every private hospital refused to care for the COVID-19 patients, the public facilities have been mobilized to treat patients with COVID-19. This meant that the previous role of public facilities, which cared for the people with disabilities, HIV/AIDS, tuberculosis, migrant workers, homeless, and low-income people, stopped working for the vulnerable population but mobilized to treat the COVID-19 patients without any buffering measures. The pandemic revoked the importance of public health and social care infrastructure that cares in insecure time, which failed to protect the most vulnerable people in the pandemic. Sexual and reproductive services provided by public facilities (public hospitals and public health centers) had been affected. Still, those who are accountable do not seem to realize nor monitor the result of deprioritized public health services during the pandemic yet. Korean civic society organizations continue our collective action calling for more significant national investment to strengthen social safety nets and public services (People's Solidarity for Participatory Democracy, April. 26th, 2021). Still, there has been no significant response from the Korean government.

The impact on healthcare accessibility was not limited to the vulnerable population who depended on public health facilities, as most private hospitals refused to care for people who are not confirmed to be COVID-19 negative. This meant that pregnant women with abdominal pain and fever had to wander the streets looking for the hospital to receive the unknown COVID-19 infection. One man uploaded this tragic story on the website (used for the Petition to Blue House) accusing the fault of the emergency delivery system during COVID-19, which lead his unborn fetus to death and his wife into danger (Hankyoreh, Dec 21th, 2020).

**Patient right violation and Obstetrical Violence**

The patient rights were heavily violated during the pandemic, as the Korean government and health facilities prioritized minimizing the risk of infection before the patient-centered care. Partners could not participate in the delivery process (even though they are not COIVD19 infected, nor have they had any symptoms), whatever the delivery method was. Most health facilities stopped Rooming-in services and forbid partner and family visits to the postnatal & neonatal ward, depriving them of the initial formation of intimacy in the newborn's early life. This arbitrary policy adopted by health facilities without scientific proof also made women with mental disabilities and disease even more vulnerable to postpartum depression and anxiety.

Women with COVID-19 also had a severe violation of patients' rights and dignity, as they had no choice but to accept Cesarean Section in negative pressure operating room. This was not only the case for the current infected women, but also for the women who had contacted the COVID-19 patients (South Korea has strict quarantine measure, which isolates people who had approached with the COVID-19 patients for two weeks), and even those who recovered from COVID-19 in early pregnancy. This is not based on scientific evidence that says there is no benefit of Cesarean Section in COVID-19 positive pregnant women (Cai et al., 2021). According to doctors affiliated with the Association of Physicians for Humanism in Korea, there were various cases of pregnant women in labor who were denied their essential healthcare services (fetal/maternal monitoring, pharmaceutical interventions for safe delivery and labor pain management, etc.) because of their "unclear COVID-19 status".

We argue that the coercive measures by the government prioritizing COVID-19 elimination encountered with an authoritative/market-driven healthcare system lead to obstetrical violence in South Korea, increasing the already top-level Cesarean Section rate even higher The Cesarean Section rate in Korea was 49% in 2019 and estimated to be 52.8% in 2020 (Healthcare Bigdata Hub, accessed June 5th, 2021).[[3]](#footnote-3)

Also, women living in the rural area where geographical access to health facilities lacks a difficult time as the public health program of gynecologic visit (a regular visit by medical staff for prenatal and other obstetrical & gynecological services) were stopped. This meant they were on their own to make their prenatal visit to the nearby city or skip the healthcare utilization. Also, most public health services operated by public health centers, including prenatal/postnatal childcare classes, health promotion classes, pre-wedding medical check-ups, STI tests, and infertility services, were stopped.

**Good practice: COVID-19 testing policy with Sexual minorities**

In May 2020, a cluster infection in a gay bar in Itaewon triggered hateful sentiment fueled by the homophobic media environment. While the media and public opinion shared negative stories about sexual minorities, the local government of Seoul Metropolitan city responded quickly. The local government formed a joint response task force with an advocacy group for sexual minorities, asking for their local knowledge. As a result, the sexual minorities coordinated response TF decided to enable anonymous free COVID-19 testing for those who visited *Itaewon* and promoted this decision to apps and online networks that are mainly used by sexual minorities. This helped LGBTQ people to test for their goods without risk of being identified.

**Legal, Policy, or other Changes affecting the SRHR unrelated to COVID-19**

South Korea is experiencing the record-breaking demographic change and the sociocultural upheaval associated with the new feminist movement. In 2019 alone, there were two significant events: the large-scale digital sex crimes known as the "Nth Room" case (CNN, January 15th th, 2021) and a monumental ruling that the abortion ban was unconstitutional. Unfortunately, the Korean government has not yet directly promoted or actively advocated sexual and reproductive health, apart from the lukewarm response to the above two issues.

The "Nth room" case raised the alarm in Korean society about "digital sex crimes." A group of cybercriminals has used social media and bitcoins to target and exploit a range of women by illegally filming or blackmailing them. However, legislative and institutional reforms for the punishment and prevention of such organized and barbaric crimes are still progressing at a very slow pace (Choi & Kwak, 2020). While the fake news with victim-blaming sentiment spread across the society, the accusation of sexual offenses continued one after another, which led to legal revisions to protect and support the survivors and victims for the physical and psychological recovery and rehabilitation for social return (The Diplomat, April 14th, 2020).

Changes related to sexual and reproductive health are still very passive or accidental but slowly incorporated into national plans. Appendix1 summarizes the national strategies and their SRHR-related contents announced from 2020 to 2021.

**Changes of financial support/aids in SRH programs in international cooperation**

Before the COVID-19, the proportion of health programs in total ODA was 11% (as of 2017), making the 8th bilateral aids for the health sector. According to the OECD-DAC Creditor Reporting System, while DAC member countries on average support 44% on health sector general(code 120\*) and 55% on the Population policies/Programs and Reproductive health sector(code 130\*), the South Korean government support 93% on the former and only 7% on the latter, respectively. In multilateral aids, the health sector comprises 14% of total aids. However, the budget on population policy and reproductive health had been declining since 2013. In short, SRHR has occupied a minimal area in South Korea ODA and is currently on the decline (OECD DAC, 2020).

After the COVID-19, the Ministry of Economy and Finance (MOEF) cut the budget of ODA to replace the national disaster support and summoned Korean staff back to Korea. The MOEF explained that the cut in aid budget was inevitable due to the COVID-19 crisis. The budget cut was 267.7 billion won, which is around 240 million US$ (MOEF Briefing, April 16th, 2020).

The fields regarding SRHR of KOICA(Korea International Cooperation Agency) are classified into health care and gender equality. The former includes providing essential maternal and child health services, including family planning counseling and services, contraceptive tools and services, and prenatal/childbirth/postpartum services. The latter includes securing basic human rights, including improving sexual and reproductive health and rights and strengthening the maternal and child health service. Unfortunately, as the Korean aids system fragments SRHR projects into health and gender equality projects, official data SRHR aid is not available. However, we tracked changes in business size by searching for a few keywords to see if the budget for sexual and reproductive health has decreased after COVID-19.

Compared to prior COVID-19, the total amount of foreign aid in the area of sexual and reproductive health in South Korea has increased by approximately 153.2% after COVID-19 [Table 1]. Due to lack of information, it’s hard to ascertain the change in the amount of aid annually, but family planning and HIV/AIDS & STD programs in 2020 decreased compared to 2019. The rest of the programs, reproductive health, human resources, and administration have also reduced contribution [Table 2].

However, a careful interpretation of data is needed. Since the data provided by Korea Official Development Assistance (KODA) is limited, information in Table 1 and Table 2 may not reflect reality. For instance, most aid programs are multi-year plans, not the one-year program. Thus, it may be pointless to interpret annual comparisons. Also, some of the data, especially of 2019, does not have complete information, and the information on 2021 donor aid is not released yet.

**Table 1 Number of projects and the total amount of aid in the area of SRH provided by South Korea (unit: USD million, %)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Year** | **# of programs(or plan)** | **Amount of foreign aid** | **Year-over-Year Growth** |
| **2018** | 28 | 17,687,502 |  |
| **2019** | 13 | 2,998,069 | -83.0 |
| **2020** | 15 | 7,590,907 | 153.2 |

Data: Korea Official Development Assistance(https://www.kodaportal.go.kr/portal/main)

**Table 2 A foreign aid information of SRH programs provided by South Korea (unit: USD million)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **2018** | **2019** | **2020** |
| **Family planning** | 1,374,558 | 2,711,782 | 1,776,632 |
| **Reproductive health** | 13,827,889 | null | 4,761,937 |
| **HIV/AIDS & STD** | 849,496 | 286,287 | 124,935 |
| **Human resources and administration** | 1,535,559 | 0 | 927,403 |

Data: Korea Official Development Assistance(https://www.kodaportal.go.kr/portal/main)

**Appendix 1. SRHR related law and policy change during 2020-2021 in South Korea**

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| --- | --- | --- | --- |
| **Date** | **Government Master plans** | **Laws** | **Contents related to SRHR** |
| 2020. Feb | The 1st Master Plan of Policies to Prevent Violence against Women (2020~2024) | Framework Act on Prevention of Violence against women  Act No. 16086, Dec. 24, 2018 | * Emphasizing on the preemptive regulation, investigation, and education * To Change the benefit and protection of the law against sexual assault crimes to ‘crimes of impairing sexual self-determination’ *\* (’53-’96) ‘Crimes related to chastity’ → (’96-present) ‘Crimes of rape and sexual harassment.’* * To strengthen punishments for various types of violence against women such as stalking, Intimate Partner Violence, and online grooming * To enhance the safety and personal protection by isolating offenders from victims *\* No mention of medical assistance for physical and psychological health* |
| 2020. Dec | The 1st Master Plan of Youth Policies  (2021-2025) | Framework Act on Youth  Act No. 16956, Feb. 4, 2020 | * Nothing related to SRHR * To expand eligibility of national health check-up to all of those who are in their 20s and 30s  *\* SRHR-related services are not included in the benefits package of the basic health check-up* |
| 2021. Apr. | The 4th Master Plans for Healthy Family (2021-2025) | Framework Act on Healthy Homes  Act No. 15350, Jan. 16, 2018 | * To improve legal support and system for birth registration procedures for single father or home childbirth * To change the principle of determining a child's last name from paternalism to mutual consent * To engage policy research and social discussion on single birth using assisted reproductive technology *\* “It is necessary to review the necessity to improve system and to research related issues such as the status of sperm donors, children’s right to know, and bioethics regarding egg and sperm donation and surrogacy.”* * To strengthen protection and support for victims of domestic violence and child abuse *\* No mention of medical assistance for physical and psychological health* * To discover Adolescents At-Risk and strengthen the protection and support system: such as integrated information system, consultation in conjunction with the foster care support center, and intensive programs related to suicide, delinquency, and depression * To expand medical support for adolescent parents related to pregnancy, labor and delivery, and childcare \* To gradually expand the eligibility: targeting from the current 18-year-old to 19-year-old, ultimately to 24-year-old |
| 2020. Dec | The 4th Basic Plans on Low Birth Rates in Aging Society (2021-2025) | Framework Act on Low Birth Rate in an Aging Society  Act No. 12449, Mar. 18, 2014 | * “Securing sexual and reproductive rights throughout life” is specified as the 5th strategic task in “1. Creating a society where we work together and care for each other” one of the four strategies * 3 Major Initiatives: by shifting paradigm from maternal health for fertility to universal coverage of sexual and reproductive rights, by supporting health with a life cycle approach y, and by guaranteeing healthy and safe pregnancy and childbirth * 3 Major changes: to expand the target criteria for HPV vaccination to female and male adolescents, to expanse menstruation-related social security, to provide the demand-oriented pregnancy and childbirth support for the underprivileged * Nothing related to sexual and reproductive health for those women and men aged 65 or more |
| 2021. Jan | The 5th Comprehensive Plans for Promoting National Health2030 (2021~2030),  A.K.A.  Health Plan 2030 | National Health Promotion Act  Act No. 15339, Dec. 30, 2017 | * Include 6 divisions with 28 key tasks * To enforce the AIDS screening and treatment system and improve the national awareness to eliminate the stereotypes and discrimination, in “Prevention and management of infections and climate change diseases” division * To strengthen the Maternal and Child Care, in “health care by population”: decrease mortality of pregnant with high risks, encourage the breastfeeding, * To promote the sexual reproductive health by improving access to contraceptives for adolescents |
| 2021. Jun | The 2nd Master Plans for Public Health and Medical Services (2021-2025) | Public Health and Medical Services Act  Act No. 15440, Mar. 13, 2018 | * To build the maternal health delivery system, especially in remote areas for labor and delivery * To designate a disabled-friendly OBGY clinic \* No mention of an action plan or indicator |

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1. most of measures to support finance and employment have been corporatarchy [↑](#footnote-ref-1)
2. One survey conducted for 500 working mothers (296 respondents) living in Seoul, the capital of South Korea, reported that only 3% of precarious workers used the family care leave while 14.2% of full-time or permanent contract workers used the leave <http://news.khan.co.kr/kh_news/khan_art_view.html?art_id=202012271131001> [↑](#footnote-ref-2)
3. the Cesarean Section rate was estimated by using the number of C-Sections provided by Health Insurance Review and Assessment Service. [↑](#footnote-ref-3)