[page 57]

**Traditional Beliefs and Adequate Prenatal Care in Urban Korea**

**Emily E. KIM**

INTRODUCTION

Regularly visiting a medical doctor is only one of many prenatal options available in developing countries such as Korea where health care, fragmented into competing modes, reflects changing values in society. The gamut runs from hospitals and private clinics with Western-trained doctors to herbalists ready with Chinese medicines, from elders full of advice drawn from folklore to pharmacist-diagnosticians stocked with a myriad of drugs, some quite potent, that they dispense according to one’s ailment. Clients may consult one source, none, or several, the last labeled the “gambler’s mentality” — a non-systematic cafeteria-style approach to medical care: a check-up here, an herb there, some vitamins tomorrow, and taboo food restricted today.1

Although the incidence and character of traditional birthing beliefs and the pervasiveness of traditional practitioners have been studied in rural Korea,2 there have been no studies on the extent and character of traditional beliefs in urban women to examine the effects of these beliefs on prenatal care. Prior literature reflects the relevance of such demographic factors as education and infant death on family planning and fertility issues,3,4 while recognizing the impact of such traditional values as son preference.5 This paper quantifies indices of traditional beliefs and examines the impact of those beliefs on the adequacy of prenatal care sought by clients who delivered at two university hospitals located in Seoul. Specifically, this study examined whether adherence to traditional beliefs involving acceptance of Confucian prenatal tenets or herbal medicine use interfered with completion of full prenatal care.

METHODS

A cross-sectional study was conducted among women delivering at either of two university hospitals in Seoul during the month of June 1985. Seventy-one women who had delivered in Severance or Sunchanhyang hospitals were identified after delivery and interviewed before discharge during one of the [page 58] biweekly visits to each institution. Not included in the study were women who had delivered on or after a given day of interview, yet were discharged before the subsequent day of interview. For example, those patients who delivered Friday, thus unavailable that day for interview, were discharged by Monday, the next interviewing day. Oral interviews were structured with a standard set of questions and conducted by a native Korean Red Cross Volunteer with five years experience in an obstetric unit. Responses were recorded at time of interview. Medical records were consulted for verification of demographic data. No refusals were met in the course of the study.

The questionnaire was designed to obtain information on parity, age, educational level of respondent and husband, source of prenatal care, timing and number of prenatal visits, usage of alternative care (midwife, church), and usage of traditional care as well as traditional concepts about child-bearing.

Adequacy of prenatal care was classified by Kessner’s methods.6 Adequate care was defined as nine or more visits with the first visit occurring in the first trimester. Inadequate care consisted of four or fewer prenatal-visits or care that started during the third trimester. Combinations other than these are considered intermediate care.

Traditional care is defined by a high score on answers to questions about physiology, endorsement of the tenets of taegyo (Confucian-based prentional beliefs), and the use of hanyak (Chinese herbal medicine).

Each respondent was asked three questions concerning the physiology of conception and childbearing. Scientific answers were rated at 1, traditional answers at 5, and common sense retorts at 3 (a category containing religious or don’t know answers as well). The scale of responses ranged from a low of three to a high of twelve. These were the questions asked:

1. How is the fetus conceived?

1-egg and sperm 3-intercourse 5-no menses

1. How is the gender of the baby determined?

1-X, Y chromosomes 3-God’s will 5-acidity of diet

1. How can one discover the gender of the baby?

1-amniocentesis 3-don’t know 5-shape of tummy

ultrasound

The Confucian tenet taegyo, translated literally, means umbilical cord teaching evincing the belief that baby and mother are more than physically linked — that emotions and ideas are transferred as easily as oxygen and [page 59] nutrients are through the umbilical cord Respondents were asked whether they believed in taegyo and what that entailed. Recommended practices included listening to nice classical music, reading good books, thinking good thoughts, and keeping peace of mind (by, for example, not arguing with one’s husband). Looking at attractive babies in pictures was advocated as a means towards achieving a pretty baby of one’s own.

Other traditions require an actual transaction for goods or services. In this category fall seeking the services of an herbalist, a fortune-teller, or a shaman, in order of present popularity. Herbal medicine is a convenient treatment which requires only a visit to report one’s symptoms to the herbalist who in turn will create a medicine to treat the condition. The fortune-teller and shaman consult and control unseen powers and spirits.

RESULTS

Overall, 55% of the women received an adequate level of prenatal care, 31% an intermediate level, and 14% an inadequate level of care as defined by Kessner (Table 1). This rate of participation compares favorably to that of urban women in the United States7 and surpasses Korean national statistics.8 The group was remarkably homogenous, consisting of married Korean women between the ages of 22 and 36 years, inclusive (Table 1). Conspicuously absent from any group were distinctions of age, marital status, or race that are associated with high rates of inadequate care in other countries, i.e., no teenaged,single, ethnic minority women. Older women (28 years and greater) were more likely to have adequate care. The women as a whole were well educated,averaging 13.2 years of schooling.

A lower educational level was associated with inadequate care. Forty-four percent of women with less than twelve years of education received inadequate care versus eleven percent of those completing high school. The education level of the husband, a rough indicator of the couple’s socio-economic level, was similarly associated, with a slightly higher significance (Table 1), a parity greater than one correlated with inadequate care. Thirty percent of women with at least one previous child received inadequate care versus eight percent of nulliparous women (Table 1). [page 60]

Table 1. Adequacy of prenatal care by maternal demographic characteristics

 Levels of Prenatal Care

 Adequate Intermediate Inadequate

TOTAL 39 (55%) 22 (31%) 10 (14%)

AGE

22-24 years 8 1 2

5-27 years 13 3 3

28-30 years 12 12 3

31-33 years 4 5 2

 34-36 years 2 1 0

EDUCATION OF MOTHER

more than

12 years 2 3 4

12 years 18 13 4

less than

12 years 19 6 2

EDUCATION OF FATHER

more than

12 years 0 4

12 years 11 7 3

less than

12 years 27 3 15

PARITY

1st child 31 16 4

previous child 8 6 6

A score of less than nine on responses concerning physiological beliefs (that is, more scientific responses) was far more prevalent in women receiving adequate care (91%) than those receiving intermediate (71%) or inadequate (64%) care. Answers ranged from a sophisticated grasp of physiology encompassing the union of egg and sperm, X and Y chromosomes, ultrasound and amniocentesis to more earthy conjectures regarding the joining of man and woman, acidity of foods, the relative strengths of the man and woman, and the way the baby sits in the womb and kicks (Table 2).

Traditional beliefs remain strongly entrenched in the women in this sample. Taegyo, a central tenet of traditional care, was cited by 79% of mothers as a beneficial influence on the baby’s health. Advocates of taegyo monopolized the group receiving adequate care. Fully 92% of mothers receiving adequate care cited taegyo versus 64% and 60% among women receiving intermediate and inadequate levels of care,respectively (Table 2).  [page 61]

Fortune-tellers and shamans have little appeal in this population (three consultations for the former; none for the latter), but herbalists continue to prosper. Twenty-four percent of the women took hanyak during pregnancy, 76% of users for pregnancy-related reasons (Table 2). Unlike the more popular taegyo, however, hanyak usage is not associated with any difference in the adequacy of prenatal care.

Table 2. Adequacy of care by components of traditional care.

 Levels of Prenatal Care

 Adequat Intermediate Inadequate

 %, N = 39 %, N=22 %, N=10

PHYSIOLOGY BELIEFS

less than nine 90\* 77 50

TAEGYO 92 64 60

HANYAK 18 27 0

\* all percents are column percents

Table 3. Adequacy of care by components of traditional care, stratified by age

Component Age Levels of Prenatal Care

Adequate Intermediate Inadequate

%, N=21 %, N=4 %, N=5

N=18 N=18 N=5

PHYSIOLOGY BELIEFS

less than nine

more than

28 years 90 25 20

less than

27 years 89 89 20

TAEGYO

more than

28 years 86 33 60

less than

27 years 100 72 60

HANYAK

more than

28 years 24 0 0

less than

27 years 11 33 0

[page 62]

OTHER EXPLORATORY FINDINGS

Mothers garnered information on antenatal care from a variety of sources (Table 4). Fifty-two percent of mothers consulted some form of media (TV, magazines, books); twenty-three percent consulted their elders. Thirteen percent remained aloof from advice and relied on “common sense” or prior experience; 23% did not cite any of these resources. Women in the last category, labeled “other,” learned from school, doctors, friends, and family. (These sources were consulted by women in the previous categories as well.) Women who consulted the media were more likely to receive adequate care (65%); those who shunned the influence of media and relied only on “common sense,” prior experience, or the advice of elders were more likely to receive intermediate or inadequate levels of care.

Table 4. Adequacy of care by sources of prenatal information consulted

 Levels of Prenatal Care

 Adequate Intermediate Inadequate

%, N=39 %, N=22 %, N=10

None (0) 3\* 18 40

Elders (1) 8 18 20

Media (2) 51 27 40

Both (1) & (2) 15 5 0

Others (4) 23 32 0

\* all percents are column percents

SUMMARY

Although prenatal care is one aspect of medical care in which minimum standards have been agreed upon regarding the initial visit, the number of visits, and the content of care,6,9 the problem of participation remains — motivating and enabling expectant mothers to seek prenatal care and to follow medical instructions. Studies in Britain, the United States, and France suggest that certain demographic features — such as being a young, single mother, of high parity, low social status, and low educational level, who [page 63] belongs to a disadvantaged ethnic group — characterize those women who received inadequate prenatal care.7,10,11 Similar studies of smaller scale in urban areas of Papua New Guinea and South Africa associate inadequate prenatal care with unstable relations with partners, inferior financial support, high parity, and rural residence, while previous troublesome deliveries and pregnancy related symptoms encouraged attendance.12,13 The South African study found the use of traditional healers associated with an increased likelihood of obtaining adequate care in the case of a spiritual healer; no association was noted if an herbalist was consulted.

In this study, demographic features, wherever present or distinguishable, paralleled results of previous studies in the field. A higher educational level of wife or husband ana lower parity were associated with adequacy of prenatal care. Women with inadequate care were more likely to have a less sophisticated grasp of physiology and to believe in taegyo. A low traditional physiology score (80% of women) and an endorsement of taegyo (79%) were associated with a seven times and four times increased likelihood of adequate prenatal care,respectively. Multivariate regression analysis showed that taegyo and hanyak remain significant despite controlling for demographic factors of age, education,and parity. Hanyak (24%) was not associated with any difference in adequacy of prenatal care, and other traditional approaches to care were quite uncommon.

It appears that there was a simultaneous embracing of two seemingly dis-parate health care systems, taegyo and Western medical care, among women in the adequate care group. This behavior is not in line with the “cafeteria- style” approach to health care cited earlier, which Yoon (1) associated with haphazard and discontinuous medical treatment, but resembles instead a more conservative and safety conscious “cover-the-bases” mentality.

Medical systems available for consultation included cosmopolitan (Western or scientific), East Asian (hanyak, acupuncture), folk (fortune-teller, shaman), and popular (taegyo, elders, relatives). The cosmopolitan sector was consulted usually on an ongoing basis by these women. In contrast, hanyak was used for spot treatments of specific symptoms such as morning sickness, indigestion, “anemic tendency,” and vaginal discharge. Several special concoctions were available as well 一 a traditional mother’s medicine taken early in pregnancy, an “expecting” medicine taken one month before delivery, and a miscarriage prevention medicine to firm the uterus. Considered milder by users than Western medicines because of its herbal nature, hanyak is deemed less likely to injure the fetus. Indeed, only two women notified their doctors of hanyak usage. The folk sector was rarely consulted by these women,  [page 64] although some admitted that their mothers or mothers-in-law would seek advice from the fortune-teller or shaman, usually for gender determination.

The popular sector of health care contains the individual, family social network, and community beliefs. It is a lay, non-professional orientations in which illness is first defined, health care activities initiated, and sickness sometimes managed. Self-treatment by individual and family is the first therapeutic entity resorted to by most people across a wide range of cultures. Indeed, only two women did not suspect pregnancy within eight weeks. This section has been little studied; it is typically regarded as crude and folksy. For example, in this population, elders regarded the maternal diet as a factor in gender determination (a function of acidity) and in fetal malformations (raw fish,squid, and clams considered weakening to fetal bones). Pregnancy itself was considered beneficial to the health by ridding the body of bad blood.

Taegyo is demarcated from such elders, recommendations by its easy coexistence with Western concepts and care and easily distinguished from the “common sense” approach to prenatal care of women following no health regime. Taegyo is a popular health belief retained by “modern” women. Although mothers-in-law in the past have enjoyed great authority over their daughters-in-law, younger women have partially thrown off the yoke. Only half preferred a son, 20% a daughter, and 29% either. These women are compromisers who, although they themselves reject fortune-tellers, allow their relatives to consult them. They are aware of, but rebuke elders’beliefs, turning instead towards more scientific approaches to physiology. These women were not the “pregnant part of the family” noted in rural studies, passive and accepting. Yet family cohesion was evidenced by the rarity of a woman who was alone in the hospital without relatives sprawled on adjacent beds or floor. Western medicine had not severed the family from the mother; indeed in most cases, family members stayed with the mother day and night, sleeping on empty beds or on the floor.

This study has several important limitations. University hospitals are the top rung of the referral ladder. As prestigious institutions housing sophisticated technology and well-trained staff, they provide tertiary care for emergency deliveries received via the emergency room or by referral from lesser equipped facilities. However, the majority of patients arrive of their own volition; they choose a university hospital from reputation, recommendation by family, doctor, or friends, or prior experience with that particular hospital whether for prenatal care or a previous medical problem, Whatever the reason for admission, the woman is cast into a select group. Only 69% of urban women deliver in a hospital or institution.8 As noted earlier, the group of [page 65] women in this study was quite homogenous, lacking a differentiation in age, ethnicity, and marital status; however, this situation is more common in Korea, a country of one highly conforming race, than in countries of diverse races and creeds such as the United States or Britain.

CONCLUSIONS

These findings suggest that some traditional and modern practitioners and practices can coexist without one infringing on the other, and furthermore, may actually work to mutual benefit by encouraging health-seeking behavior. This finding is in concordance with the South African study that found the use of spiritual healers positively associated with obtaining antenatal care yet found no correlation with the use of herbalists.13 Health services can be evaluated by analyzing cures as dangerous, neutral, and positively beneficial. Clearly, taegyo falls in the neutral and perhaps benencial category. On the positive side, taegyo provides a social context for pregnancy that professional health givers may not, and it is associated with adequacy of prenatal care. There appears to be no negative effects. The effects of hanyak, in contrast, have not been well evaluated. Although users deem it milder than Western medicines, other Korean mothers eschewed medications of any type. Usage of hanyak is neutral in its association with adequacy of prenatal care. An informed evaluation would require that the many hanyak medicines be evaluated pharmacologically.

Findings indicate several interventions available to increase adequacy of prenatal care: increased educational level, health education at school and in the media, targeting of multiparous women, and non-discouragement (if not encouragement) of taegyo.

[page 66]

**NOTES:**

A multiple regression model was used to examine ana identify the independent contribution of age, education, parity, and three factors of traditional care, taegyo, hanyak, and the traditional physiology score. Factors paralleled the univariate analysis. Taegyo, parity, the physiology beliefs score, and education remained significant (in order of significance); hanyak and age remained insignificant.

Table 5. Multiple regression analysis of adequacy of prenatal care

 Standardized

 regression 2 Probability

Risk factor coefficients r (p) value

Constant 0.000 0.095

Age (years) - 0.142 .013 0.211

Education (years) 0.283 .171 0.013

Hanyak\* 0.018 .007 0.867

Taegyo 0.283 .077 0.008

Parity\*\* - 0.269 .057 0.017

Traditional Score\*\*\* 0.214 .039 0.053

Total .364

\* scored 0 for none, 1 for user.

\*\* scored 0 for no previous child, 1 for previous child (ren).

\*\*\* scored 0 for 9 or more, 1 for less than 9.

**REFERENCES**

1. Yoon, S. A legacy without heirs: Korean indigenous medicine and primary health care. Soc Sci Med 17:1467-1476, 1981.

2. Sich, D. Traditional concepts and customs on pregnancy, birth and post partum period in rural Korea. Soc Sci Med 15B:65-69, 1981.

3. Bumpass, L., Rindfuss, R. R., and Palmore, J. A. Intermediate variables and educational differentials in fertility in Korea and the Philippines. Demography 19:240-60, 1982.

4. Park, C. B., Han, S. H., and Choe, M. K. The effect of infant death on subsequent fertility in Korea and the role of family planning. Am J Public Health 69:557-65, 1979.

5. Park, C. B. Preference for sons, family size, and sex ratio: an empirical study in Korea. Demography 20:333-52, 1983.

6. Institute of Meaicine, National Academy of Sciences. Infant Death: An Analysis by Maternal Risk and Health Care. Contrasts in Health Status 1:59. Washington, D.C., 1973.

7. Cooney found 18.4% of women receiving late or no prenatal care (starting in the third trimester) in an analysis of 85,000 live births in NYC in 1981. Cooney, J. What determines the start of prenatal care? Med Care 23:986-997, 1985.

8. In 1982, the Korean Institute of Public Health (KIPH) estimated that 77.3% of urban [page 67] women consulted prenatal services with an average of 3.6 visits. In the present study, even the inadequate group approached that loose definition of utilization. Only one woman completely avoided prenatal services; this amounts to a consultation rate of 93% by KIPH standards. Korean Institute of Public Health, National Family Health Survey Data, 1982.

9. Gortmaker, S. L. The effects of prenatal care upon the health of the newborn. Am J Public Health 69:653-660, 1979.

10. Lewis, E. Attendance or antenatal care. Bri Med J. 284:788, 1982.

11. Blondel, B., Kaminiski, M., and Breart, G. Antenatal care and maternal demographic and social characteristics. J Epidemiol Community Health 34:157-163, 1980.

12. Marshall, L. Influences on the antenatal clinic attendance of Central Province women in Port Moresby, PNG. Soc Sci Med 21:341-350, 1981.

13. Larsen, J. V. and Middelkoop, A. V. The ‘unbooked’ mother at King Edward VIII Hospital, Durban. S Afr Med J 62:483-6, 1982.