A Study on the Improvement of Community Health Practitioner Programmes

— Based on an Evaluation Workshop of the CHP Program —

A Research Report
to
World Health Organization

Korea Institute for Health and Social Affairs

A Study on the Improvement of Community Health Practitioner Programmes

- Based on an Evaluation Workshop of the CHP Program -

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by

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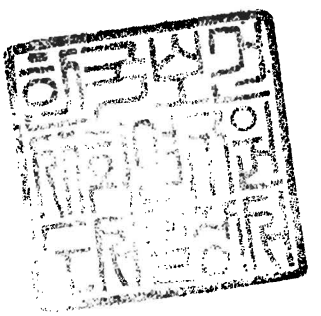


Foreword

Since the WHO Alma-Ata Declaration concerning primary health care, this concept has become widely known throughout the world. All nations have adopted the WHO goal of "Health for All by the Year 2000" and are presently in the process of implementing primary health care.

In Korea, the concept of primary health care has also been adopted to solve urgent problems of health services in the remote, rural areas through the development of a new health care provider; the "Community Health Practitioner(CHP)". These health care providers have been installed in health posts in the villages. For the past 10 years as the "Entry Point" for primary health services, the CHPs have contributed a great deal in the field of primary health care.

Nevertheless, in the 10 years' time, the country has changed tremendously, in various aspects; the socio-economic state, disease patterns, population structure, the health environment of rural communities and health policies.

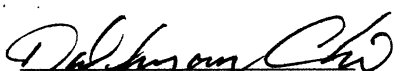
The CHP program, therefore, should also be reviewed. For this purpose, a workshop was held for experts in primary health care, to review and effectively adjust the role and function of the CHPs to fulfill the changing health demands of the people in the areas presently served by health posts.

Analysis was made of the content of the materials of the workshop, the questionnaires and also the contents of discussions at the workshop. The results of the analysis showed the following: government policy to support function and role adjustment, new program directions, improved training methods and improvement in post operation.

It is expected that the results of this study can be utilized for the future direction of CHP program and the emphasis of health promotion aspects of the entire population in our country.

The financial support of the Western Pacific Regional Office of World Health Organization, as well as the sincere assistance of Dr.K.S. Lee, Scientist of the Western Pacific Regional Office of World Health Organization would be very much appreciated.

The Korea Institute for Health and Social Affairs wishes to express sincere appreciation to all the members who participated in the Workshop.



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I. INTRODUCTION

1. Study Background

It is well known that the concept of Primary Health Care has largely been strengthened and more widely known in the world since the 1978 WHO Alma-Ata Declaration of "Health for all by the year 2000 through Primary Health Care".

The Korean Government has also had difficulty with an insufficiency or lack of health services in the remote rural areas of the country. Although over the past 30 years various approaches and programs have been developed and applied to try to solve the problem, none were practical or workable, nor could they be adapted as a successful way to further develop health services.

In 1976, the Korea Health Development Institute(KHDI) was established with the major objectives to develop village level health workers and to solve deeply rooted problems in the health services of the country. A demonstration project for a comprehensive approach to health services for village populations was developed and carried out from 1977 through 1980. As the result of the project the Community Health Practitioners System was finally adapted and was expected to fulfill the primary need for health care for the villagers and plans for further development were approved.

In the meantime, as already mentioned the Alma-Ata Declaration was made. This was timely to the problem of health services in rural Korea and the necessity of a primary health care program was felt even more strongly.

A special law, "Special Law for Rural Health Services", was established by the Government at the end of 1980. Under this law two newly categorized health care providers were defined, one was for physicians as "Public Doctors" and the other was for nurses as "Community Health Practitioners(CHP). The Public Doctors work in the Health Subcenters at the township level under the direction of the County Health Centers and the CHPs work at the further remote village level. The CHPs posts were supposed to be the entry point for local health problems and their worksites were the areas villagers live and health needs exist. The CHPs were recruited and the total number eventually reached 2,038 CHPs working in their health posts. Under the law they operated the posts independently for a reasonably large proportion of the services.

In this connection, the CHPs' contributions in the fields of preventive measures, emergency treatments and referring, and follow up services or general health check up services for the family including school children and youth have been greatly appreciated in promoting the health state of the population of the villages.

Nevertheless, over the 10 years' time, following the growth of the nation, there have been great changes and developments in health related environments such as population size and age, rapid urbanization, up-grading of the educational level and the total coverage by health insurance schemes, and these have necessitated amendments to health policies. Naturally, the CHPs' function must be included in these amendments for further improvement and effective activities. One component which was of concern was payment and post security in order to maintain the CHPs as long lasting and professional health care providers.

Presently, the government is in the process of some further amendments of the Special Law with the intention of changing the status of the CHPs from a temporary one to a permanent civil servant status in order to stabilize these health care providers as professionals.

As mentioned above, the CHPs' program has been carried out for 10 years already but within a tremendously changed environment. This certainly needed to be reviewed and the functions and the contents of the work redefined as necessary. Therefore a general review and evaluation were made with the assistance of WHO to analyze the existing resource materials as well as summarize the overall consensus of leaders and advisors concerned with primary health care.

2. Problems of the CHP Program

The following were the problems raised in the past concerning the CHPs' program.

First, what are the real achievement in the CHPs' work and how can it be re-directed to encourage improvements in their work in the program?

Second, how can the role and function of CHPs' be evaluated in order to encourage further improvement and how can the training curricula be developed accordingly?

Third, when the CHPs become civil servants, how can the CHPs work be efficiently fitted, as well as inter-related, and a referral system developed within the infrastructure of the health network to fulfill the demands of village habitants?

Fourth, how can a supervisory system be developed in technical and administrative or managerial work among CHP personnel when they become civil servants when it is well known that the supervisory work, particularly the technical part, has not been well developed in the past.

Fifth, how can a system be developed that ensures that all kinds of supplies, such as drugs, equipment and health education materials for the public are properly and adequately supplied for the CHPs' work?

Sixth, how can CHPs' posts be managed if the income decreases? If the CHPs' work for the preventive measures is strengthened and less therapeutic work is done, the income of the posts will less than at present, this means the finances for post operation will significantly be short. How can it be adjusted?

Seventh, how can community participation be strengthened further? While community participation is one of the important factors in primary health care service it has been the most under developed part so far, how it can be strengthened and progress effectively in the future?

Eighth, how can the CHPs be formalized as professional health care providers for health services at the village level?

3. Objectives

1) To evaluate existing materials and resources concerning the CHPs' work.
2) To identify strategies for improvement of the CHPs' function and training methods through analysis of the materials concerned.
3) To identify appropriate solutions for the problems raised about the CHPs' program, in the system and managerial components.

Ⅱ. Materials and Analysis

1. Restriction of the Study

The Webster Dictionary defines the key words concerning the CHP program as follows: "System" is composed of 'a complex unity formed of many often diverse part subject to a common plan or serving a common purse', and "Management" is defined as 'the act or art of managing as more or less skilled handling of something'. Following the above definitions, it is clear that a comprehensive approach is necessary for the practical conceptualization and evaluation of the items in this study.

It is also said that, according the System Theory, the following are required in order for a "system" to work: Production, Support, Maintenance, Adaptation, Management and Functional Cooperation.

Adapting the above, "production" includes the objective population, service area and local community. The supportive factors require financial support, policy, specific technical knowledge and skill and for maintenance, it is necessary that there be appropriate selection of personnel, training, social function and motivation.

To fulfill the factor of the adaptation, research and development as well as technical and structural changes are required. Further, for the management factor, the allocation of resources, control and coordination are necessary.

This study, therefore, should comprehensively cover all of the above mentioned factors and again for this reason comprehensive approaches including the overall primary health policy and network in the country needed to be examined to identify the inter-related factors. Nevertheless, it was thought preferable to limit the area to the CHP system by concentrating analysis on the CHP's function only, in order to let the government adapt the outcome fully for further effective improvement or modification of the system. This is why the content of this study, as mentioned in the "background" chapter was limited to addressing the problems with the CHP program which were evaluated in order to identify possible solutions.

2. Resource Materials

Analysis was done of resource materials collected on a wide scale nationwide, which included the following made available from the research institutes, the schools concerned and our own study outcomes: the results of performance training, research outcomes on individual performances and material on operation of the posts. A recent questionnaire survey done by Korea Institute for Health and Social Affairs (KIHASA) from September to November 1990, during in-service training courses for the CHPs which including a total of 1,614 CHPs and the material from an evaluation workshop on Community Health Practitioner Program in Primary Health Care which was held from October 21 to October 23, 1991.

The 60 participants represented various professions in health related field, were government official at the central, provincial and county levels including community health practitioners (CHPs).

The program included a keynote speech on "Primary Health Care and Role of CHP" and a special lecture on "Trends in Primary Health Care Implementation in the Global Context". Three papers were presented on Achievement of CHPs and their future utilization, paper 1, Redirection of CHPs Function and Training Program, paper 2, and Strategies for Improving CHP System Operation, paper 3.

There was also a group discussion and plenary sessions.

3. Analysis

All existing resource materials were collected and the results of the questionnaires and the contents of the workshop were analyzed to identify facts such as actual numbers, percentages, and means according to the study objectives.

I. Fact Finding

1. Analysis on the Present Status of Operation

1) Achievement in the CHPs Work *

The outcome of the content analysis of the workshop held between October 21 and October 23, 1991 was as follows:

(1) Methods for Anaysis and Materials

Collecting data and materials on the CHPs program for the study purpose has never been easy in the sense of quantity and also quality, for while the program has been carried out for 10 years there has been continuous change. Nevertheless, materials were collected as shown in the Table 1.

Table 1. Characteristic grouping of resource materials utilized

Subject	No.	Remarks
Performance Analysis of CHPs'	19	Utilization rates of posts, Time allocation for each performance, Level of work, Working sites, Management of posts and demographic materials
Role, function, achievement and constraint	4	
Satisfaction	8	
Curricula	6	
Evaluation of work	2	
Cost of operation	3	
Others	8	Analysis of pilot area, Referring, Supervision, Case reports, Traditional habits for diseases, Utilization study
Descriptive writings	10	
Total	60	

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* It was summarized the paper on "Achievement of CHPs and Future Direction" presented by Dr. Mo Im Kim, Dean, College of Nursing, Yonsei University during the above mentioned workshop.

These 60 resource materials were analyzed using the method describe in Holland(1983) and Greene and Symons-Morton(1984)s' model of health service system evaluation approach. The factors analyzed were process evaluation, impact evaluation and outcome evaluation.

Though these evaluations were taken to cover the defined areas comprehensively there were, unfortunately, inevitable limits in the materials. The following results were obtained.

* Process Evaluation

In process evaluation, the following are identified as external features and included: health service provider, methods, contents, time allocation, character of the population, budget and personnel. However, under the inevitable limits of the resource materials, the findings were substituted with following: the satisfaction of work of CHPs, ways of work, quality of service and time allocation and also the cost of services.

* Impact Evaluation

The factors for impact evaluation differ from study to study, and were not clearly defined. The factors examined, therefore, included changes of KAP on health, frequencies of services, understandings of services or acceptance of services, effectiveness, inclusiveness and state of cooperative work among the health network.

* Outcome Evaluation

The outcome evaluation had to be expressed by the quality of life showing changes in mortality and morbidity, however, these data were not easily obtainable in such a short time, and also the changes in mortality and morbidity may reflect some other factors such as socio-economic factors even though health services are affected. In this study, therefore, other substitutes were utilized. Fortunately, there were two comparative studies available for use on changes in the health status of the population.

(2) Results of analysis

A. Process Evaluation

a. The CHPs' Job Satisfaction

For CHPs' job satisfaction, the dissatisfaction rate between 1982 and 1986 increased from 3% to 14%. The remarkable change as that 75% of the "generally satisfied" and 23% of the "satisfied" in 1982 had changed, showing that in 1986 more than a half were "satisfied"(52%).

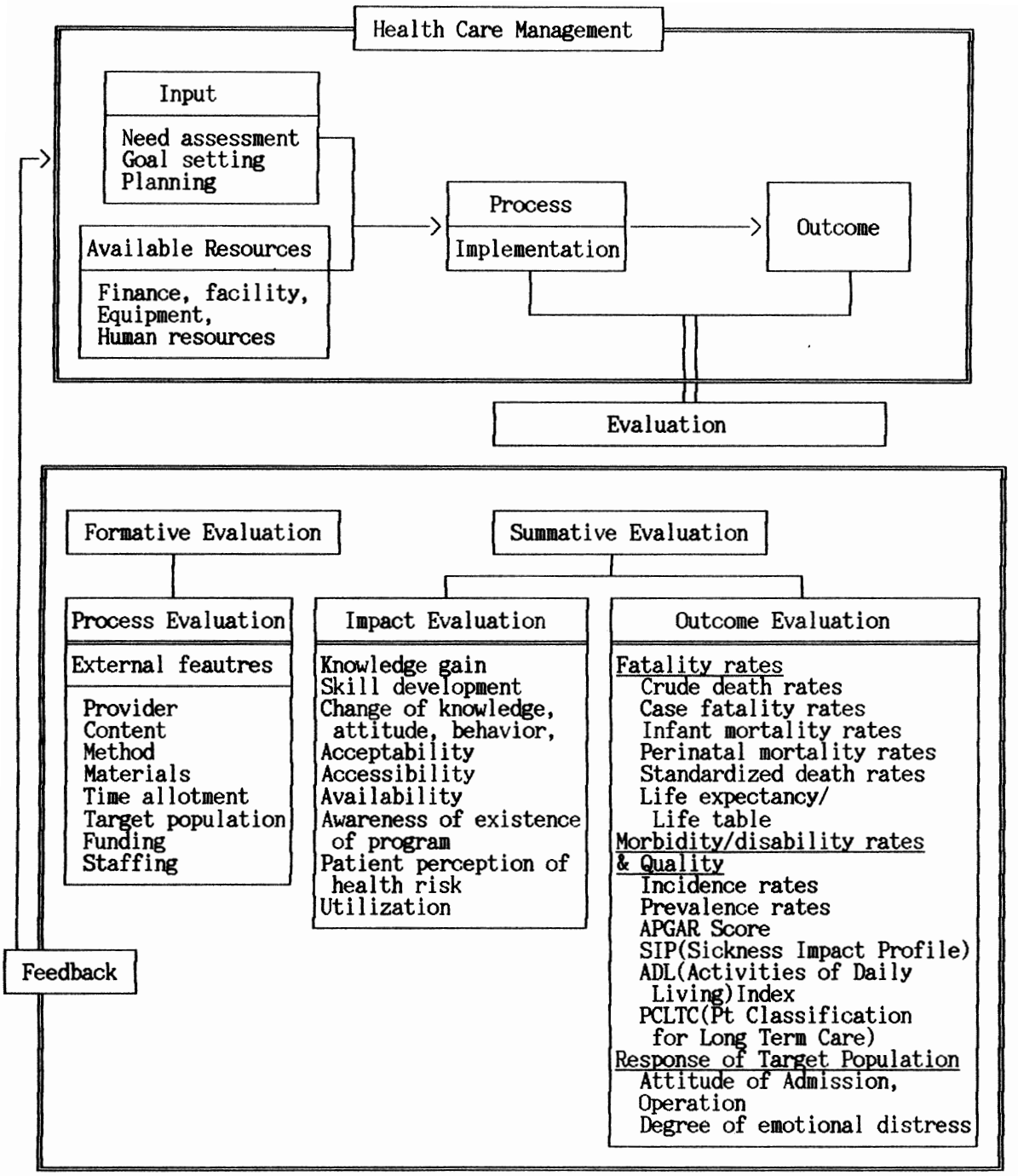

Figure 1. Model for Evaluation of Health Care

Source: Holland, W.W.(1983), (Ed.) Evaluation of Health Care, Oxford: Oxford Univ. Pres
Greene & Symonus-Morton(1984)

Further detailed analysis on the work itself, site of work and pay, showed that the CHPs felt satisfied with the work itself but not with the sites or the pay. The unsatisfied rates had increased remarkably in the four years. According to most, CHPs are happy in their work but they feel the work sites and the pay are not adequate.

b. Expertise of Health Care

The quality of the CHPs' contribution was evaluated by the villagers as well as by professionals concerned.

* By Villagers

The results of the research done by the Korea Institute of Population and Health(KIPH, the previously KIHASA) in 1982 showed the following, 96% of villagers interviewed were satisfied with the therapeutic work, 87.3% with the preventive work.

For villagers who had used the posts 68% of them reported that they were fully satisfied and 25% felt that the service was just average, as a whole the reliability toward the work of the CHPs was shown to be very high.

* By Professionals

A team composed by 10 family physicians who were presently in the training process and six nursing professors evaluated the CHPs. This team checked 24 CHPs' posts, checking every post for 2 days each by the team and the CHP was interviewed. The quality of performance was checked by the physicians and other management and general functions were checked by the nursing professors.

ⓐ For the process of care, history taking was done in the manner and the ways of asking that were excellent and in this way the CHPs could maintain a good relationships with the villagers. The quality of the physical examination following the patients' complaints were sufficient in 70% of the cases. In the aspect of treatment of the patients, the physicians commented that 90% were either sufficient or average. Health education by the CHP's was given for the whole family instead of only the patients themselves and this was evaluated as "very much appreciated".

ⓑ Adequacy of drug prescriptions and care were 90% in repeat cases, 78% in new cases.

© Nurses with longer working experience showed a better level in the quality in their work.

ⓓ The referral system for high level treatment should be strengthened. While the number of drugs for the CHPs' use is limited, there was no evidence of excessive use of drugs.

ⓔ Most of visitors to the posts were patients(78.9%), however, the CHPs, through these patients, worked out family oriented approaches, with necessary health education, in which preventive measures could be introduced effectively for the future.

ⓕ Although the work of CHPs was generally appreciated, their work covered only 50% of caseload they were supposed to serve. The reasons given were as follows, short work experience, shortage of equipment needed, excessive workload, and in this connection they were not able to attend to the less important aspects of the work.

ⓖ According to the evaluation of the physicians on the team, the right decision was made for the referred cases 85.7% of the time in 1981 and 72.5% in 1983.

c. Time Allotment

ⓐ The time allotment for direct and indirect encounters was checked, 67% of patients cases were seen within the working hour between 9:00 a.m. and 6:00 p.m., however, it was found that one third of the cases visited outside of the working hours. This shows that the CHPs' working hours were not regular and for all practicality they generally worked 24 hours a day.

ⓑ Data obtained from interviews with 60 CHPs in 1986 showed that the time allotment for the CHPs was mostly spread between 5:00 in the morning and 12:00 midnight and it was not clearly defined.

© Comments in an investigation of the CHPs program steering committee members by KIPH showed that 31.5% of committee members had the idea of a "no off day system" and 8.3% thought one day "once every 2 weeks" was adequate, indicating that most of the members think the CHPs should be available for 24 hours a day, waiting for clients in order to be totally responsible for the local health services.

As the above mentioned comments and figures show, the work of the CHPs was positively accepted not only by villagers but also the physicians and nursing professors, and the directors of health centers evaluated the expertise of care as sufficient and acceptable.

d. Low Cost

ⓐ According to data obtained by the Korea Development Institute (KDI), in a study of the cost effectiveness of health centers, health subcenters and CHP posts, per visit cost for physician in the health centers was ₩1,062, by public doctors in the health subcenters, ₩1,667 and by the CHP, only ₩391. The level of financial self support was 17.6% in the health centers with physicians and 25.4% in the CHPs' posts. This data demonstrates that the CHPs' posts can be considered more effective and cost-beneficial.

ⓑ Another study done by KIPH in 1985 involving a total 978 habitants also showed that 78.9% of the villagers thought that the cost of the care in the posts was inexpensive. Further it showed that, out of 2,082 total visits to health institutes in one month, 214 cases(10.3%) utilized public institutes because of the inexpensive cost and 161 of the 214 case(75.2%) visited the CHPs posts the same reason.

ⓒ In a similar study done by Park(1986); of 69 CHP posts in Kyon Sang Buk Do area, 22 posts where the account books, were kept relatively accurately showed following, the average income per case was ₩959 and the expenses per case for non personnel costs were ₩585. However, if the cost of personnel is added, the expenses become ₩1,841 per case. Another study by KIPH in 1987 showed the cost for care was still reasonably low in the CHP posts.

B. Impact Evaluation

a. Changes in Health Awareness and Health-Related Behaviors among Clients

ⓐ A household survey on the health delivery system and a study of health status in rural communities in 1987 shown that the individual health needs differ according to the living sites, namely, people who live in remote rural villages think they are less healthy (20.3%) than people who live in other areas of the country.(city 13.4%, large township 17.7% and small township 19.4%)

ⓑ One study done in 1988 showed the percentage of feeling "healthy" decreased after introduction of the CHP posts as compared to before, and less-healthy rates increased. These attitudes might have be influenced through the CHP posts installation which caused villagers to look at their own health conditions more carefully though might be also be related to other improvements in the socio-economic status.

ⓒ Data from a pre and post comparative survey on the health status of villagers in the areas covered by CHPs posts showed a decrease in smoking, drinking and the intake or abuse of foods or drugs that people believe protect liver function, from 30.5% in 1981 to 12.9% in 1984.

The drugs used for emergencies increased tremendously from 25.9% in 1981 to 56.1% in 1984, digestives, antipyretics, analgesics, antiseptics and topical ointments.

ⓓ The same study also showed that contraceptive users increased after the CHP program and the induced abortion rate decreased.

b. Accessibility

ⓐ Concerning the use of drug stores, whereas 64.3% of villagers utilized drug stores before the CHP program in 1981, 69% used the CHP post in 1985.

ⓑ A study done in 1985 showed 49% of all villagers used the CHPs posts, 18% of them still used the drug stores.

ⓒ The survey done by KIPH mentioned in the previous chapter showed that among 2,082 total patients in one month, 877 cases(42.1%) chose health institutes by distances, in particulary 717 cases listed distance as the first priority. Since the CHP posts are closest to the villages, the accessibility is easily understandable as having high priority.

ⓓ Since 80% of the 2,082 total number of cases visiting the posts were less than 30 minutes walking distance from the post, it is certain that the factor "distance" greatly affects the utilization of the health posts.

c. Awareness of Existence of Program

A study done in 1986 showed 78% of 4,070 total households utilized CHP posts and, if in 912 households there was no event requiring a visit to the posts and 256 households where health problems were not serious enough to visit the posts were added, then it might be said that in actuality 83% of total villagers utilized the post.

d. Acceptance

An important issue was whether or not the CHPs as nurses would be acceptable to the villagers in program development although the role of nurses as health personnel in general is well understood as important and rational. In the traditional attitude of people, in a male dominant country where even in the Ob/Gyn specialty women prefer male physicians over female, it was naturally expected at the beginning of the program that there would be restraints. However, there was no evidence to support this kind of concern. The KIPH study in 1982 on CHPs' work showed 98.7% of population accepted their work as satisfactory. Similar study results were found in a 1984 study in Kyong Sang Buk Do(96.0%) and in a Chun La Nam Do study in 1985(72.3%).

e. Coordination and Continuity of Care

ⓐ According to study data from 1982 on CHPs, the patient referral rate was 2.1% and the analyzed data of the CHPs' record forms showed that 3.4% of the cases were referred. It is presumed that the referral rates are between 2.1% and 3.4% though the two data source differ.

ⓑ The institutions to which patient were referred different from case to case. The data of 1983 showed that 47.1% were referred to hospitals and clinics, 24.2% to health centers, and the data in 1984 showed 83.3% were referred to hospitals. Among the hospitals, however, local clinics were well utilized showing 53.3% of the referrals.

ⓒ About the discharge of patients from the referral institutions, the CHPs were informed mostly by the family members, 74.6% of the cases, and only 5.1% directly by the institutions.

ⓓ For continuity of care 84.0% of the CHPs would like to get information about the patients' conditions and also information about follow up care directly from the referral institutions.

ⓔ The CHPs would like to increase continuity of patient care and to do so within the primary, secondary and tertiary care system. They would also like to solve difficulties concerning emergency care through coordination and training programs being adequately developed so that more efficient care could be provided to the patients.

C. Outcome Evaluation

a. Effectiveness of the work of the CHPs

Two studies on "An analysis of the effectiveness of CHPs' work in remote rural areas(1988) and "Review of health status of the villages with CHPs posts" had the following results on the effectiveness of their work.

ⓐ There were no significant changes in the fields of maternal and child health and family planning programs or other public health activities with the CHP post installations, the utilization rates, however, for therapeutic measures increased significantly (visiting the posts) showing the positive results of the work of CHPs. In the same period as there was an increased utilization rate for the CHP posts, there was also an net increase for the use of other public health agencies such as public hospitals, health centers and also drug stores.

The following figures shows this increase:

* per person per year, health institution visits, increased 1.96 times
* per person per year, formal health institution, visits increased 1.29 times, namely the net increase rate was 46.2%
* Utilization rates for health institutions for 15 days (Total increase rate: 5.2% as base) Overall utilization: 9.6% decrease, Hospital and clinics: 25.0% decrease, Health center(Subcenter): 21.2% decrease, Drug stores: 48.1% decrease.

ⓑ The trends of decreasing utilization for treatment showed a trend to substituting drug store use and self-therapy to utilize the CHP posts and also an influence to decrease the use of public or even private clinic utilization through the operation of the CHP posts.

© The utilization rates of health institutions generally increased during 1981 through 1985. This was also endorsed by Song's study in 1988.

Though this study was done in only three rural areas and cannot be generally applicable to the whole country, the results showed that the utilization rates of health institutes both hospitals and clinics and even health centers did not decreased in spite of the availability of care at the CHP posts. The utilizing rates for health institutes rather increased from 12.7% in 1981 to 43.9% in 1985, health subcenters from 11.4% in 1981 to 16.2% in 1985, drug store from 24.1% in 1981 to 46.2% in 1985. Looking the figures, it can be seen the increase rate was the highest for hospitals at 31.2%, next for drug stores, 22.1% and lowest for health subcenters at 4.8%.

(3) Conclusion

The following are the conclusions from the evaluation of the work of the CHPs. Related to the contribution of the work of the CHPs to the remote, under-served rural populations and also in regarding the principles of primary health care, such as inexpensive, easy, continuous, in good quality and comprehensive as well as an adequate referral system, the CHPs' work could be evaluated as work of good quality and satisfactory in spite of requiring 24 hours of continual work preparedness.

It has generally been said that the sites of service influenced the accessibility, but it is not always apparently true. In this sense, the work of the CHPs can be evaluated as a truly meaningful system.

All of the studies showed that the CHP program has greatly contributed to the villagers transferring from drug store use to posts utilization and that the acceptability and satisfaction were sufficiently high and the program understood to provide good quality services for the under-served villagers in the country.

In general these CHP program has been well accepted either in both the developed and developing countries, looking at an example from Canada, it can be seen that Nurse Practitioners are acceptable from the following.

The Burlington Randomized Trial Study in Canada showed that one of the most reliable programs is the Nurse Practitioners Program (Parker, 1983; Standford, 1987; Spitzer et al., 1974). This study compared the clinical outcomes by physicians and nurse practitioners, in mortality, physical disability, emotional and social functions. The study results showed that the clinical outcomes of both groups were more or less the same and satisfaction of patients was 97.5%

for physicians and 96.5% for the nurse practitioners demonstrating that the NP program as a new concept was highly appreciated.

In U.S.A., NP programs in the nursing research fields are popular ones and the overall comments of the studies since the middle of the 1960s through 1990 were as follows,

a) The services provided were greatly appreciated by the habitants.

b) The NPs themselves felt competence toward their work. They felt that they were providing good quality nursing and health services for those who needed them and that they were effective and adequate health care providers.

An another study compared ante-postnatal care and delivery services done by physicians (resident in Ob/Gyn) and nurse-midwives. In the services by the latter there were fewer incidences of prematurity, infant death rates and low birth weight, and fewer abnormal delivery incidences giving proof that low cost services by Nurse-midwives can be effective.

There as not much difference in the content or process between physicians and nurse practitioners but in the case of the NP, more health education and family life helps were provided, and particularly in cases with chronic diseases the contribution of the NP made for less hospitalization, a decrease of 50%.

There are available a great number of study cases about the good quality primary health care by nurses to substantiate the value of this type of care.

In U.S.A. the Graduate Medical Education National Committee which is composed mostly of physicians made a report to the Minister of Health in 1980, recommending the following, that "the participation of nurses in primary health care is sufficient and well accepted by patients and can made at lower cost for services" and recommended the utilization of nursing personnel in primary health care for public use to provide good quality and low cost services to the people.

2) Status of CHP Training

For the last 10 years the CHP training programs have been carried out in the eight designated medical or nursing schools in the country. Its details were written in the regulations of the Special Law for Rural Health Services.

The Korea Institute for Health and Social Affairs (former KIPH) was responsible for all supportive work, such as budgeting, curricula, all parts of management of the training program, training for trainers, preparation of training materials and supervision.

Each training achool would handled the courses strictly according to the instructions.

With the completion of the training programs by over 2,000 CHP, three schools were left as permanent training school for new recruits to replace those dropping out of the CHP work. The institutions are Yonsei University, College of Nursing, the School of Public Health, Kyong Buk University and Jesus Nursing Junior College.

(1) Total number of CHPs trained

For 5 years from 1981 through 1986 the total number of CHPs trained was 2,282 in the eight designated schools.

The basic training program was completed when the number reached 2,000 since that was the number shown in the Master Plan of the Government to be necessary to provide the required services.

Since then, the drop out rates had been 8.9% to 6.1% yearly, and replacement by additional recuit training courses has been carried out with 718 additional CHPs being trained up to 1991.

The total number of CHPs trained including the drop outs is 3,002 as show in Table 2. This has been over a ten years period.

(2) Amount of budget

The total budget disbursement for 10 years is shown in Table 3. In the budget, the direct costs were transferred to the schools concerned. Those were for honorarria, travel expenses to supervise training, pay for temporary assistants employed during the course, subsidies for responsible trainers and also an amount of contingencies.

These were under 15% of the total budget for the training programs from 1981 through 1986 but from 1988 it increased to more than 15% of the total.

Indirect cost was for the production of training materials and travel expenses for the trainers when various meetings were held and amounted to only 2.1% of the total.

The largest proportion of the total budget was used for the trainees, their living cost for 24 weeks and a subsidy for their use, together these amounted to 82.6% of the total budget of the training program.

The cost including the stipends for the trainees was ₩1,269,278 per one CHP in 1981, ₩1,480,000 in 1987 and by 1991 it increased to ₩1,800,000.

The per capital cost varies according to the number of trainees and becomes more expensive when the number is small like today.(see table 3)

If a comparison is made to the cost of training during the pilot project period(1977), the cost which was US$1,000, the present cost is three times as great as at that time.

(3) Management of training

A. Role and function

The role and function of CHP were designated by the Law, the detail performances were the base. The Special Law shows the CHP's performances as follows (Regulation No.14 of the Special Law)

Therapeutic work:

a. Physical assessment to find out abnormalities
b. Referring patients
c. Treatment of frequent and mild grade injuries and emergency care
d. Treatment for the worsening of illness
e. Chronic disease care
f. Normal delivery and contraceptive appliance
g. Vaccinations
h. Medication for items a. through g.

Public health work:

a. Environmental sanitation and nutritional improvement
b. Prevention of diseases
c. Maternal and child health and family planning
d. Health education and supervision of the health of villagers
e. Other health promotion activities

In order to develop appropriate courses for the training program of the CHPs, the role and function of the CHPs had to be clearly defined. For this purpose, the institute set to establish the following.

* Comprehensive primary health care should be based on the community
* Roles and functions of CHP should be developed according to the demands of the community

Table 2. Number of Trainee by Training Institute and by Year

Training Institute	Regular Training Course							Supplementary Training Course						
	1981	1982	1983	1984	1985	1986	Subtotal	1987	1988	1989	1990	1991	Subtotal	Total
Seoul National University	64	67	61	35	44	38	309	-	-	-	-	-	-	309
Yonsei University	36	36	54	81	63	55	325	55	44	39	49	48	235	560
Chungnam National University	23	21	23	20	26	66	179	-	-	-	-	-	-	179
Jeonbuk National University	58	59	42	26	48	61	294	-	-	-	-	-	-	294
Jesus Nursing Junior College	22	-	21	24	52	49	168	65	55	49	51	52	272	440
Jeonnam National University	50	47	66	49	65	55	332	-	-	-	-	-	-	332
Gyongbuk National University	64	67	66	70	66	45	378	59	45	37	37	33	211	589
Busan National University	48	63	58	58	26	46	299	-	-	-	-	-	-	299
Total	365	360	391	363	390	415	2,284	179	144	125	137	133	718	3,002

Table 3. Budget for Training Programs for Community Health Practitioners

(Unit: won)

	Total	Regular Training Course						Supplementary Training Course				
		1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Indirect Cost	82,231,332	27,419,184	12,222,806	5,903,108	5,044,374	5,165,140	3,964,320	3,111,920	7,479,280	7,311,840	6,004,980	3,604,380
(%)	(2.1)	(5.9)	(2.7)	(1.2)	(1.0)	(1.0)	(0.8)	(1.1)	(3.6)	(3.5)	(2.8)	(1.4)
Direct Cost	624,467,229	65,976,467	69,698,332	70,144,240	70,575,706	65,440,210	76,421,960	36,983,795	36,794,560	39,492,049	45,733,910	47,206,000
(%)	(15.3)	(14.2)	(15.2)	(14.1)	(14.8)	(13.0)	(14.1)	(14.0)	(17.4)	(19.3)	(20.9)	(19.0)
Allowance	3,375,233,700	369,891,000	375,840,000	420,637,800	402,276,600	432,198,000	459,903,000	225,003,000	166,752,000	158,250,000	166,578,300	197,904,000
(%)	(82.6)	(79.9)	(82.1)	(84.7)	(84.2)	(86.0)	(85.1)	(84.9)	(79.0)	(77.2)	(76.3)	(79.6)
Total	4,086,932,260	463,286,650	457,761,138	496,685,148	477,896,680	502,803,350	540,289,280	265,098,715	211,925,840	205,053,889	218,317,190	248,714,380
(%)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)
Cost Per Trainee	1.361,403	1,269,278	1,271,559	1,270,294	1,316,520	1,289,239	1,301,902	1,480,998	1,465,457	1,640,431	1,593,556	1,870,033

* Work area can be divided into three categories, maternal and child health and family planning, and nutrition improvement and treatment of diseases and organization and management.
* Treatment as primary care should be based on the by-laws and treatment should be directed at early case finding and with conservative approach as the limit.

The above role and function for the CHP were decided by the trainers during a training course for trainers, held from February 12 to March 4, 1981 and at another workshop when there was an overall review of CHP's work with an evaluation held from November 8 through 19, 1982. According to the comments the areas to be covered by the CHPs were extended to seven from the three areas of work orginally discussed. These are listed in table 4.

Table 4. Adjustment of Role and Function of CHP

(Unit: Number)

1981			1982		
Areas	Tasks	Task Elements	Areas	Tasks	Task Elements
1. MCH, FP & Nutrition	5	28	1. Community Organization	2	4
2. Treatment	3	7	2. Work plan	4	15
3. Other Health Care	10	33	3. Health Care of Community	9	33
			4. MCH, FP	5	28
			5. General Treatment	9	34
			6. Management skill	7	11
			7. Information Delivery System	1	4
Total	18	68	Total	37	129

The role of CHP in the community is defined as, the person for health care, service provider, leader for development, educator, consultant and referrer, health team member, evaluation and research conductor, information collector and distributor.

In rural communities, 80% of the health related problems are within the limits of primary care, but as the person for the entry point, various knowledge and skill are required.

B. Management of training programs

The Korea Institute for Health and Social Affairs chose the "Competancy Based Training Method" for the method of training of CHPs under the suggestion of the CHP trainers at the CHP trainers' training workshop. As the most effective training for the professionals, it was thought to be the best method by the trainers.

The age of the trainees was limited to 55 years or younger, a schedule of eight weeks of didactical training, twelve weeks of clinical training and four weeks of community training were carried out.

The contents and time allocation were not particularly reviewed or corrected until 1986. From 1987 through the present, 1991, health care for the elderly, youth consultation, communication methods, population and welfare problem concepts, further, agricultural health care and information on health insurance were included, amending the contents in a small scale to respond to the demands of the communities.

Time allocation for didactical training was 50.6% for therapeutic care and 49.4% for non-therapeutic care for 1981 to 1986. In 1987, it was reviewed and adjusted to 48.7% and 51.3% respectively. Further, in 1988, with the introduction of health insurance, the proportion for therapeutic care was cut down to 44.8%, again it down to 38.1%. The time left was allocated to the other training elements.

With those changes, the lecturer orientation course was newly developed in 1987, to match to the newly amended teaching schedule in the training courses.

The clinical, practical training was for 2 sessions, each 12 weeks of clinical and 4 weeks of local community practice. Hospitals, clinics, mid-wifery clinics and MCH centers, health centers as well as the CHPs' posts were selected for the clinical training sites.

The internal medicine clinical training, was carried out by the family medicine department, teaching all of the following, assessment for the major complaints and other abnormalities, methods of physical assessment, necessary laboratory tests, methods of tentative diagnosis, treatment, consultation, education, follow up care and recording.

In Ob/Gyn, normal delivery care, contraceptive supplies, including IUD insertion and after care services, were the areas the trainees needed to learn. In pediatrics, well baby clinic care and vaccination skills needed to be learned

and in the general surgery department, emergency care, methods of referring patients and injury treatment needed to be taught for the trainees to get the knowledge they would need in the future.

The training in the local community was a kind of orientation course designed to help the trainees find the best way of settle in the community, coordination groups to approach, contact with the villagers, and other connections that would be important factors in their near future.

The time allocation of 12 weeks of clinical training was as follows: two weeks in internal medicine, two weeks in the surgery department, four weeks of Ob/Gyn, two weeks of pediatrics and one week in the skin clinic and one week in the ENT and eye clinic. Four weeks of local community practice course were allocated, two weeks in the health center and two weeks in the CHP posts. The contents of training courses was reviewed occasionally to correct deficiencies.

The evaluation of the training was done throughout the process of the course, attendance rate of 20% to 35% for the didactic course, 35% for clinical training and 10% in the local community practice making for a minimum total of more than 70%, otherwise, further complementary programs were required in order for the trainee to complete the training.

The three designated schools as formal CHP training facilities were instructed to follow the instructions given by the Institute (KIHASA), some constraints exist in these schools, which must be solved. They are as follows:

a. The training of the CHP should be based on "competency based training" to obtain appropriate knowledge and skill, however, some lecturers as trainers show a lack of knowledge of the CHP program and also often supportive factors are in sufficient.

b. All those designated schools do not have independent facilities for the training and there are no teachers who are particularly employed only for this purpose, this is why, for the CHP training, facilities and teachers (trainer) are always in short supply.

c. Evaluation tools for didactic as well as clinical training courses have to be developed accurately and rationally.

d. Whether this training program is to continue to be carried as it has been, or modified either to be included in the existing basic nursing curricula or developed as an independent institution like the master course in the other fields, the program for the future needs to be considered.

The research work done for the improvement of the training program for CHPs is as below:

Table 5. Research for improvement of CHP training

Year	Subjects
Feb.12 - Mar.4, 1981 (3 weeks)	Trainers' training program developed, for CHP training(WHO)
Nov.8 - 19, 1982 (12 days)	Research committee operation for a long term plan for CHP program(WHO) Study on the feasibility of integration of CHP training into basic nursing education
Nov.23 - 30,1983 (7 days)	Evaluation tools for Competency Based Training Methods(WHO)
Oct.15-20, 1984(6 days) 1986	Workshop for integration of CHP training(WHO) Development of instructions for CHPs' in primary health care(WHO)
1987 to the present	Studies on improvement of CHP training, function and system reviews

3) Present Status of CHP's work

(1) Population

The population size covered by a post was originally to be from 1,000 to 5,000 according to regulation 15 of the Law. However, it has been modified due to various conditions so that it is 300 persons for some island areas and 500 per inland remote areas.

Table 6. Re-arranged Population

1981-1986	1987 to present
Population above 1,000 under 5,000	Population 500 for remote inlands Population 300 for islands

Nevertheless, one study findings showed that the average population per post was 1,452 persons in 1987 and 994 persons in 1991. This figures is largely affected by the general decrease in the rural population in the country.

The actual population mentioned above is the population in the catchment areas and not the administrative fixed one by the Government.

(2) Characteristics of the areas

The areas covered by the CHP can be divided as follows:
66.0% are mountenous and agricultural, 17.3% are very remote, 13.0% are fishery areas and 1.4% are mining areas and 1.2% are on the border with the North Korea and 1% are urban setting.

In the areas where the CHPs are supposed to work, as was fixed by the Government, the following conditions can be found, 56.3% have drug stores (staffed by personnel without formal licenses as pharmacist, but simple permission for the stores), 17.4% have herb medicine practices and persons who are actually working as physicians but have no license were found in 45.8% of the areas.

Though it is said that the level of income and education have increased and methods of transportation have become easier and also there is health insurance available to everyone, the rural population still actually appreciates these illegal services.

Further, the CHPs' work is closely related with the following institutions. The percentages are, for areas with CHP posts that have the named institution, 86.9% with schools, 31.4% with agricultural cooperatives, 28.7% with a police station, 23.0% with a post office and 11.2% with general stores and 30.5% with other facilities such as factories, churches, resort areas.

(3) Surroundings of the CHPs' work

The CHPs were supposed to live within the areas of their work. The rate of "live with family" was much higher in the cases of the CHP who had a long working period (over 50% of the CHPs who had worked more than 5 years live with their family)

A high percentages of the CHPs who were assigned to mining fishery areas lived alone and 29.2% of the CHPs worked on Saturday afternoon and Sunday, also.

Overtime work for work out of normal working hours (9:00 a.m.-6:00 p.m.) averaged 86 min. in the morning and 109 min. in the evening showing a total of 195 min.(3 hours 15 min.) of overtime work.

The salaries of the CHPs' were covered half from the central government, that is the Ministry of Health and Social Affairs, and the other half from the local government.

In addition, a subsidy of the amount of ₩70,000 monthly could be given by the managing committee of the CHP posts for CHPs working in remote inlands areas and ₩120,000 for CHPs in the islands areas.

Those amounts are given in the instructions by the Ministry of Health and Social Affairs as the maximum limit and 75.3% of the CHPs were able to get the subsidies but it was received regularly by only 59.8% of the CHPs.

The rests either did not receive any subsidy or it was very irregular, and the average amount of subsidy was ₩61,000.

When asked about satisfaction with pay, 96% of the CHPs said it was "unsatisfactory" even though the number rating their work as "satisfactory" was high and they wanted the security of the assignment(93.2%).

Under the endeavour of the Ministry of Health and Social Affairs, an Amendment of the Special Law was approved by the National Assembly this year, 1991, to change their assignment status to that of formal civil servants from the previous temporary status.

(4) Performance of the CHPs

As the entry point to health services, the CHPs are providing comprehensive services to individuals, families and even the society itself.

Among the services provided, however, the most delicate point is focused on the therapeutic services. Particularly since the introduction of health insurance in 1988, the number of cases for treatment has changed. These changes are analyzed as follows:

The average number of patients per month was 197, with 71.7% being under health insurances, 24.9% as medicaid cases and 3.4% as pay cases. The age distribution for the year showed, age of 0-4 years, 7.8%, 5-19 years, 20.8%, 20-30 years, 17.6%, 40-59 years old, 31.3% over 60 years, 22.4%.

The average number of patients was 218.6 persons in the agricultural areas, which was the highest and 158.7 in other areas. Fishery and mining areas had a higher rate of medicaid cases than in the other areas.

By system there were 38.9% for respiratory system, 19.0% for digestive system, 17.9% for joint and muscle problem compound symptoms, 11.6%, injury, 5.9% skin problems, 3.3%, emergency and others, 1.2%. With the introduction of rural health insurance, it was expected that some changes following the new system might be seen. However, the figures during transition to the new system showed no change for 23.4% of the posts, an increase for 48.7% and a decrease for 27.8%.

According to the characteristics of areas, in the fishery areas 53.0%, in the remote areas 61.0% and near the border of the 38th Parallel areas 55.6% showed increases.

Further in the treatment of these patients, the CHPs were working for the individual, the family or the community on whatever problems they had that the CHPs might help by either assisting directly or referring and then following them, spending a long time for a family to help them solve their problems. According to a direct check on the allocation of their working hours, an average of 19.5% of the time each day was spent for patient treatment, 30.8% for health education and consultation and 49.7% was spent for paper work. From these figures, it is known that at present the CHPs spend more time for public health work than the treatment.

4) Operation of the CHP posts

The aspects of support and the supervisory system, supplies and funding and community participation were checked.

(1) Supportive system within the county

It is well known that for the health services of the population in any area to be effective, all health personnel concerned should be a team and work in a close cooperative service system. There are available to the CHPs the following institutions: the health centers, health subcenters and the CHP posts. The work plan, operation and evaluation must be done as a team to provide the best service for the people of the area. Unfortunately, however, the team does not work properly at present.

The study findings on the CHP work analysis and training program development in 1987 showed that for congratulation related to treatment of patients health care resources were used in the following order: physicians in the hospitals, clinics near by, public health administrator of the health center, public doctors in the health subcenter, the director of health center, and the public health nurse in the health center respectively.

Also the CHPs meet the health workers (nurse aides) in the township for the referral and consultation, work plan, information dissemination and technical advice, group or individual teaching and monthly meetings.

However, those contacts are not for the purpose of health improvement, but only as part of the routine activities (for MCH, FP or TB control) of these workers as government health personnel.

In a study done in 1990, 60.3% of CHPs suggested that a team working with the public doctor in the health subcenters was urgently needed, though, at present not possible.

Though, it is clear that the major objectives of health personnel were in

the prevention and treatment of disease, rehabilitation and the general improvement of the health of the population, promotion of health status through the present organization shows difficulties in maintaining the objectives related to administrative structure and personnel.

Namely, the health center operates under the "Law of the Health Center" and personnel are government employees and health subcenters can be set up following the article of the Law, "when the chief (the county chief) requires a health subcenter under the health center to carry out the health program in the area, it can be established by the Presidential Law and Regulations". And although the public doctors, as new health care providers, work as the directors of health subcenters, they are not the government employees, but are recruited under the Special Law of Rural Health and serve instead of serving in the military draft services which Korean men are obliged to serve.

As mentioned, apparently, none of these personnel arrangements were made systematically, so that the character of the personnel here and there are different in their status for their work as well as in the matter of supervision and naturally difficulties arise. The relationship of these personnel are delicate under such situations. The public health doctors are under the direct supervision of the Ministry of Health.

On the other hand, the health workers who are nurse aides and full time government staff are working mostly either in the township offices or health subcenters, and the CHPs are working in the villages under the Special Law as temporary workers.

In these situations, adequate coordination or team work cannot be expected to develop. In addition to these conditions, the geographic factors also hamper team work and coordination of professionals in their work.

When transportation services were examined, it was found that for 70% of the posts the bus services was available every 2 hours and in 10% there was no bus service at all. The distance to health subcenters showed that it took on average of 127 min.(2 hours) and to the health centers 70.8 min.. More time was required to the health subcenters was because the transportation within the township areas was not as convenient as it was to the county seat.

(2) Supervision

The Article 23 in the Special Law mentions the following,

① the county chief should be responsible and should supervise the CHP posts.

② the county chief can transfer the responsibility of technical advice and supervision to the health center directors or health subcenters, and if these people are not available this job may be carried out by private clinicians in the area.

The above articles in the Law may bring confusion in that the CHP work is administratively under the chief of county and technically under the directors of either the health center or health subcenters or even under private clinicians meaning that supervision is carried out in two ways.

Further complicating the conditions under which the CHP work are the following: in the Ministry of Health and Social Affairs, community medical department of the medical affairs bureau is responsible for everything concerning the CHPs, and at the provincial level, the public health administration section of the public health department is mainly responsible for the CHP work or sometimes, it is the family health or medical and pharmaceutical section, at the county level in the health centers, it is handled by the public health administration section, but the technical portion is done by the sections concerned. All of which leads to many complications in the system.

A study done in 1985 analyzing the supervision done by the health center directors of the CHP work showed that since the majority of the health center directors were not medical but public health administrators, the supervision of the CHP work by those directors was not efficient as a matter of natural course and it was impossible. The directors, in the supervision of the CHP posts expressed the following problems: no systemic base(36.4%), poorly developed system (36.4%), short of funds(16.8%), short of time(6.5%), short of transportation availability(5.2%) and others(3.9%).

Since the above study done 6 years ago, the present situations in this field is not clearly known. However, it is true that the supervision of the CHP work is not an easy matter.

A study in 1990 showed the average number of visits per month to the posts by the member of health center was 2.17, and the visits to the health center by the CHP was 1.32 times. Concerning contacts with staff of the county office 32.5% of the CHPs reported having contact, 34.2% once a year, 26% twice a year, 21.4% once a month, and 17.7% only once every 5 to 7 months.

The CHPs meet for the operation and management of the posts, mostly with the chief of the managing committee, the chief public health administrator in health center and the director of the health center respectively.

Through the above figure concerning the supervision, it is easily seen that there are large scale variations in the effectiveness of the supervision according to the contents of supervision, the methods, evaluation and understanding of the work and the level of knowledge, and also ability to supervise from person to person. Presently, there is almost no supervision on the technical aspects but some administrative advice available.

In conclusion, it is necessary to develop a process for supervision of the CHPs that contains a sense of administration, the status of personnel as a leader and acceptor, definition of authority, definition of content and methods of feedback. Further improvement in the system are keenly required.

(3) Supply system

The managerial instructions for the posts according to item 45, specify that it is possible to purchases drugs and equipment through the CHP posts managing committee fund, however, except in some urgent cases requests should be made to the health center to let the health center purchase supplies and equipment for all the posts at the same time.

Therefore, the regular supplies of drugs and equipment are made available through the health center within the regulation or in exceptional circumstances the CHPs may make their own purchases. However, other materials such as vaccines, health education materials, audiovisual systems or some necessary transportation assistance for health care and preventive measures, are not covered by item 45 and as of yet are not sufficiently systemized or stabilized from the central to the local government offices and it shows in large scale differences from county to county.

In the MOHSA of the central government, the CHP posts belong to the medical affairs bureau as well as the public health bureau, which has administrative responsibility supervised by the medical affairs bureau and other work concerned with the material supplies is done by other departments of the public health bureau. Further as one moves to the provincial government, the county offices or health centers are responsible, and these supply systems are mostly not operated systemically, but rather filled with confusion and complexity with nothing much stabilized or well developed.

(4) Operating Fund of the Posts

The Article 24 in the Special Law for Rural Health Services states the followings, 1) The country and province should subsidize the county for the installation of the CHP posts and for necessary expenses, 2) The central government should provide fund for one half of the operation costs of the posts yearly and the provincial govenment should subsidize one third of the yearly costs. However, presently the operation costs for the posts have to be raised by the post itself.

The figures concerning the financial situation for the 2,038 CHP posts are as follows: A study done in 1987, found the average income per month was ₩ 221,678 in 1984, ₩265,901 in 1985 and ₩257,302 in 1986 showing a slight yearly, increase. The main source of income was from treatment (72.6%).

Disbursements for the same years were shown to be 74% of the total income which meant they stayed within their budgets of these disbursements, 50.9% were to purchase drugs.

It is also found that in the island areas self-support for the post operation was not possible as the income level was only 55% that of the inland posts.

Following these figures, the MOHSA subsidized at the rate of ₩100,000 per month, 52 CHP posts and it is planning to increase this to 88 posts. With the application of health insurance beginning in 1988, and the posts were designated as applicable sites for insurance coverage, and the income of the posts increased over previous years. Figures from the 1990 study, in the agricultural and remote areas show the average incomes to be between ₩420,000 to ₩530,000 respectively, and in the fishery and mining areas ₩440,000 and ₩260,000 respectively, that is a little less than the other areas.

Including the subsidies from the central govenment as well as the county, 257 CHP posts, that is 12.6% of the total, were receiving operation funds from other sources.

The official report from 1990 for the year showed the average income per month for the posts was between ₩300,000 and ₩570,000 with the post in Jeju province reporting the lowest at ₩250,000.

As was already mentioned over 90% of the total income came from patient treatment. The level of income has increased greatly compared to the beginning of the program. The level of subsidy was only 8% in Kyonggi and Kangwon Provinces, 1% Chungchong Nam Province, 5% in Chunla, less than 3% in Kyongsang Buk Provinces and 5% in Jeju Province.

As discussed above, since the operation of the CHP posts is financially

dependent upon its own income and the main income is from the fees for treatment, when CHPs' services are concentrated more on preventive measures than on therapeutic treatment, operation funds will have to be supplied by either the central or local government.

There are also the members of the managing committees for the CHP posts which on an average are composed of 15.8 persons and meet 2.8 times yearly. The assistance level for the committees for the CHP posts was shown to be 16.0% positive, 64.5% not much and 19.5% none.

When the installation of the posts was initiated by the committees which provided the land for the post building or assisted to secure a public place, provided various furniture and equipment, funding for opening the posts was also made available. However, after that, in the actual operation with the new post, the committees did not actively participate in the operation and management.

The committees, according to the managerial and operation instruction for the committee, are supposed to positively participate in the field of the work itself, the pay and travel expenses and accounting, covering the entire managerial and operational elements of the post operation. However, when the status of CHPs is transferred to that of civil servants, the committees should also be shifted to cover the welfare problems in the areas concerned.

(5) Community Participation

In Korea, as an important component of the successful development of primary health care programs, community participation has been designated as the first priority, the managing committees of the CHP posts and village health workers' work were considered to represent participation by the community.

For the past 10 years, however, the status of these activities, as mentioned above, were fairly minimal and not well developed to work positively.

The village health workers were assigned an average of six persons per the posts, the attendance for the meetings averaged 4.8 persons, the frequency of meetings was 11.9 times a year which meant the meeting were held an average of once a month. They were supposed to exchange information and disseminate health education content for the villagers. The details were as follows, 50% were involved in case findings, and referrals, 45.9% in collection of information on changes of location among the villagers, 45.7% particularly, in collecting informations about deaths, 44.4% in patient findings and referral 38.2% in identifying birth cases, and 18.5% in follow up checks.

The total contribution by the committees average a 41.0% performance rate.

2. Improvement of CHP Post Operation

In order to provide direction for improvements in the CHP post operation, the contents of the evaluation workshop and also the contents of its group discussions were analyzed. The CHP program was developed in connection with the primary health care process and it has been in operation for 10 years up to the present, so all of the elements needed to be reviewed and evaluated to identify direction for further improvements in the work of the CHPs, directions for changes in function, training methods and operation methods.

1) Provision of primary health care in the future

(1) The direction of primary health care program in the country certainly has to be amended from the point of finding solutions to the basic health problems and needs. It must step up objectives to promote the health status of the overall population in prevention and promotion of health.

(2) In the promotion of positive health status, the objectives should include the following health related components: policy development, environment, life-style and infrastructure throughout the central, provincial and county organization network.

(3) The primary health care program should be focused on helping each individual to have a more productive life, socially and economically and to educate people and so provide motivation for them to be responsible for their own health.

(4) The objectives of primary health care are to introduce a better life for each person by promoting active participation in their communities for this purposes.

(5) The primary health care program should strengthen the preventive measures and promotion of health through a comprehensive approach to health policy.

2) Utilization of CHPs in the future *

It is readily apparent that the population structure, disease patterns, income and the level of awareness and the health environment of the country are rapidly changing. In this aspect, the primary health care programs also have to have on going development to match these changes and protect the health of the people.

The government in the Seventh Five Year Economic Development Plan from 1992 through 1996 has plans and is commited politically as follows,

① To identify preventive measures that focus on chronic and degenerative diseases and to provide lives that are happy and of good quality for the aging society, ② To extend active health services for population groups who are vulnerable as far as health is concerned, that is children, the elderly, the poor, single householders, the disabled, the mental handicapped and for underserved rural population. ③ To provide low cost and effective services. ④ To remove elements of danger and keep the environment healthy and protect the consumers of health services, to encourage technical promotion, new drug development, the development of an efficient health network, development directed toward the opening of international markets as well as accounting for changes in disease patterns and for conditions identified in various studies.

Within the above commitment plans, the CHPs work have also largely been amended.

(1) System development of the CHP posts as an entry point to the health care system

For the underserved population, the CHP as the entry point was easy and also the only understandable point for therapeutic measure for diseases. However, if, as present planned there is a shift to preventive services apart from disease treatment it will bring confusion and will not be effective as far as the attitude of the population is concerned.

Concerning this point, the CHPs' work, so far has focused on treatment and has been positively accepted by the villagers who expressed an over 80% satisfaction rate.

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* It was presented by Dr. Mo Im Kim, Dean, College of Nursing, Yonsei University during the above mentioned workshop.

This is why the development of preventive measures following the government plan, early case finding, promotion of health, rehabilitation, etc. have to proceed along with the therapeutic measures in a well balanced state to avoid confusion in the villagers. This attitude is also the principle concept for primary health care that fortunately also introduces self-reliance and self-determination approaches.

There have been a lot of changes in the disease patterns, the aging of the population and improvement of the living standards following the pattern of other developed countries such as, increase in chronic diseases, increasing death rate for injuries, mental illness and also changes in diseases like AIDS. From this content the training curricula should be reviewed and appended as necessary.

In this situation and also during the time it takes for the status of the CHPs to be changed from temporary to permanent civil servants, the CHP posts should be further strengthened as the entry point for other health resources such as hospitals and clinics and so forth.

This system should be firmly settle between the patients and health institutions for the best possible coordination of care and continuity of services.

When CHPs become civil servants as formal govenment employees they should certainly be supervised by the directors of the health centers where their work is centered.

As migration rates from rural to urban areas continue to increase the poors in the urban areas are also increasing and in general rural people who move to urban areas are incredibly poor, and for these people the primary health care programs should also be developed. The CHP system, perhaps, can be adapted in the urban poors in health subcenters, and have the CHPs cover populations of 3,000 to 5,000 for early case finding, referrals, preventive measures, education and follow up work for people with chronic diseases and disabilities. Through this approach comprehensive health care could be provided.

A previous study had already recommended in the 7th 5 year plan extending the CHP work in the urban areas or covering this area with other nurses. This policy is going to be systemized.

(2) The CHP utilization for primary health care for the elderly

The over 65 years old population made up 3% of the total population in 1980 and 5.0% in 1990, and will be 6.8% in the year 2000 and again 13.1% in 2020 according to recent estimations. Expectation of an increasingly large elderly population is definite. The population size per CHP in remote rural area was set at from 1,000 to 1,500 in the 7th 5 year plan, and 200-300 for the island areas. This plan calls for an extention of the number of posts to 180 or more.

Presently, most of the general hospitals have to deal with long hospitalization for the elderly due to the chronic nature of their problems. At the same time some emergency patients have difficulties getting admitted because of shortages in beds. Solutions should promptly be developed before further serious difficulties are encounted.

Recently, clinics for the elderly or home care services by nurses have been started to provide a reasonable solution to these problems, further nursing home or intermediate level institutes can be devleoped for this purpose, and the CHPs can have an important role in this system, and if it is necessary, supervision by the physician system can be developed. These systems are being reviewed at present.

In Japan, the government has invested a large amount of the budget for the elderly and developed the nursing personnel bank for the purpose of utilizing nurses in this field. Perhaps, the CHPs can work in similar situations to the example from Japan.

(3) Utilization of the CHPs for chronic and long term hospitalized patient care in health institutes

Following the changes of disease patterns with increasing chronic and long term cases, participation of nurses as CHNP will be necessary.

Dr. Babara Bates who is an outstanding woman physician in USA has written that most of the above mentioned patients can be cared for by the CHNP for follow up and need only be seen by the physician on the first visit. She pointed out that the CHNP's care is more effective than just physician care and demonstrated that if the CHNP care for patients with chronic diseases, then hospitalization can be decreased up to 50%.

In the hospitals the number of out-patients per physician per day is from 100 to 200 and patients visiting for follow-up care have to wait four to five hours and then they only to see the physician for an average of three to five minutes and both the patients and the physicians feel unsatisfied with this situation. As Dr. Bates mentioned it is time to see whether the CHPs in Korea

can participate as team members under the supervision of the physicians. Perhaps, a pilot project can be developed for this system with an efficient relationship between physicians and patients and to economize hospital administration.

(4) Development of ambulatory care centers

The operation of a hopsital is fairly expensive work and there is an attempt to economize the expenses to the people as well as of the government, it may be possible if the personnel arrangement could be made adequately.

The Kaiser hospital in USA, has utilized nurse practitioners in the out-patient departments as team members with physicians. These nurse practitioners provide much of the out-patient care. Also even in private clinics the NPs have been successfully utilized to provide necessary services. For sufficient utilization of the NP, it is natural that a long period of experience is required. However, the matter needs to be reviewed to consider the feasibility and whether it can be satisfactorily applied in this country. The NP can work in partnership with the physicians.

(5) Utilization of the CHPs in schools and industrial fields

In order to utilize the CHPs in schools and industrial areas, the role and function necessary for primary care in these areas must be thoroughly reviewed. The training curricula for school health and occupational health should be included, and the contents of the curricula for CHP training programs should be amended to allow the CHPs to work in a broader fields.

The regulations in the law for "School Health" and "Occupational Health" show the tasks of school nurses or health service providers and the health services are similar to the CHP's services.

In spite of further needs for amendments to the curricula as mentioned in this paper already, without any particular additional training, the CHPs could begin to work in these two areas immediately, and through continuing education they can meet further requirements for knowledge as necessary.

To utilize the CHPs efficiently as professional personnel and to have their work effectively in the health services for the public, it is necessary to consider amending the "Medical Law" to include the CHP system as one of the special fields to be covered by nursing professionals.

3) The changes of functions of the CHPs and the training program

(1) Function of the CHP

A. The training of the CHP should be further strengthened for public health activities and the promotion of the health status of the population, it should also be focused to care for high risk populations. Therefore, health education in the training should be broadened to include more active care of patients with chronic diseases, care of the elderly, rehabilitation and mental health care, family welfare, referral and consultation. Also education should be developed to provide the knowledge and skills for early case finding and home care nursing services.

Studies done in the USA showed 80% of health care demands belong to the primary care category, and to solve these problems an average of four visits for the services are required. Practically among the primary cases, less than 50% need help from physicians, 30% of the rest can solve the problems by self-care when they learn how to take care of themselves. Diseases, accidents and death which directly or indirectly affected by life style can be prevented through improvement of life style and it is much more economic to do so than to require the services of a physician. The CHPs should work in this way, focusing on preventing of dieseases.

B. The CHPs should strive to develop a work plan and apply and evaluate it. Various programs to fulfill health demands, new methods of promoting community participation of villagers, etc. should be developed.

The CHPs have been working using self-developed work plans and it can, therefore, be said that through the CHP program, the bottom up-method has been experienced and it is possible to see how it worked efficiently and what the level of effectiveness was.

Generally in this country program proceedings, are always top-down, plans being made in the central government and ordered with targets and so forth. Many times the demands for services are not perfectly understood and in taking care to fulfill the demands, the efficiency of the program usually was in doubt.

Presently, with the development of autonomous bodies in the local government and to fulfill the demands of the local people, bottom-up programs should be carried out and for this purpose, work plan, active evaluation and managerial skill are further required.

Table 7. Monthly Average Income and Expenditure of Community Health Practitioner Post by Province

Privince		Income (Won)					Expenditure (Won)						
		(National + Local)	Income of Treatment		Other Income	Total	Personal Cost		Drugs/ Supplies	Maintenance of Facility	Purchase of Medical Equipment	Other	Total
			Income				Allowance	Travel Cost					
Gyonggi	Amount	43,200	432,400	13,200	11,200	500,000	61,192	12,770	199,793	69,452	6,642	144,871	494,720
	(%)	(8.6)	(86.5)	(2.6)	(2.2)	(100.0)	(12.4)	(2.6)	(40.4)	(14.0)	(1.3)	(29.3)	(100.0)
Gangwon	Amount	28,962	301,909	22,157	9,175	362,203	66,479	24,566	126,214	38,532	6,355	102,871	365,017
	(%)	(8.0)	(83.4)	(6.1)	(2.5)	(100.0)	(18.2)	(6.7)	(34.6)	(10.6)	(1.7)	(28.2)	(100.0)
Chungbuk	Amount	2,754	350,828	11,938	29,329	394,849	66,813	10,348	148,704	48,435	6,227	88,563	369,090
	(%)	(0.7)	(88.9)	(3.0)	(7.4)	(100.0)	(18.1)	(2.8)	(40.3)	(13.1)	(1.7)	(24.0)	(100.0)
Chungnam	Amount	1,653	371,377	2,371	39,596	414,997	64,962	36,212	197,703	41,281	26,368	41,824	408,350
	(%)	(0.4)	(89.5)	(0.6)	(9.5)	(100.0)	(15.9)	(8.9)	(48.4)	(10.1)	(6.5)	(10.2)	(100.0)
Jeonbuk	Amount	16,479	315,539	24,283	7,436	363,739	43,221	5,665	155,678	44,724	4,796	57,801	311,885
	(%)	(4.5)	(86.7)	(6.7)	(2.0)	(100.0)	(13.9)	(1.8)	(49.9)	(14.3)	(1.5)	(18.5)	(100.0)
Jeonnam	Amount	14,437	271,766	10,886	4,069	301,158	18,875	7,487	185,869	21,974	3,195	61,562	298,962
	(%)	(4.8)	(90.2)	(3.6)	(1.4)	(100.0)	(6.3)	(2.5)	(62.2)	(7.4)	(1.1)	(20.6)	(100.0)
Gyongbuk	Amount	11,192	351,152	21,638	17,787	401,769	68,648	15,829	160,558	47,259	3,783	86,489	382,566
	(%)	(2.8)	(87.4)	(5.4)	(4.4)	(100.0)	(17.9)	(4.1)	(42.0)	(12.4)	(1.0)	(22.6)	(100.0)
Gyongnam	Amount	10,033	508,050	31,306	25,734	575,123	43,998	7,699	193,174	29,424	4,485	59,247	338,027
	(%)	(1.7)	(88.3)	(5.4)	(4.5)	(100.0)	(13.0)	(2.3)	(57.1)	(8.7)	(1.3)	(17.5)	(100.0)
Jeju	Amount	13,333	195,531	38,890	3,013	250,768	33,111	7,746	70,328	32,583	1,413	35,341	180,522
	(%)	(5.3)	(78.0)	(15.5)	(1.2)	(100.0)	(18.3)	(4.3)	(39.0)	(18.1)	(0.8)	(19.6)	(100.0)

The CHPs should work to develop management information systems(MIS) and self-development of local people and also coordination of office to office should be further strengthened.

The CHP's function at the grassroots level requires a variety of systemized health information and it is necessary to computerize, utilizing health workers or village workers to collect information. To develop and manage an MIS system the CHPs have to learn skills to use these systems.

It is also necessary to develop an appropriate system as a referral system for chronic disease care and for follow up care.

In this connection, the CHPs should work on rehabilitation, education and change of life style in a comprehensively way, not only being concerned about disease treatment.

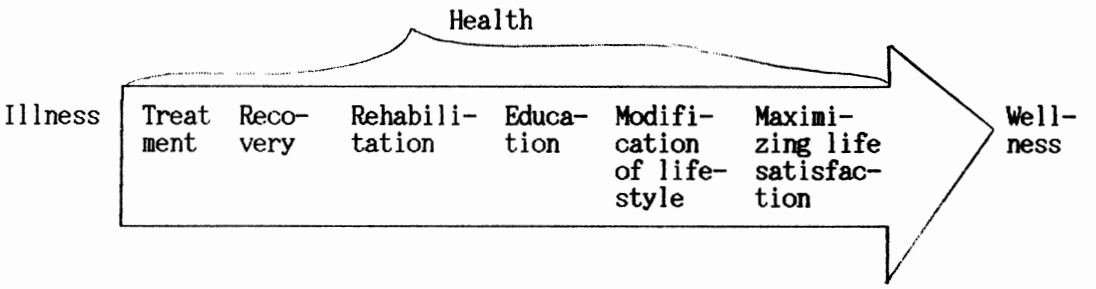

Figure 2. The Health Continuum

Source: Lorenz K.Y ng etc., Strategies for Public Health
- Toward a conceptual formulation of health and well-being -
Van Nostrand Reinhold Company, 1981

Table 8. Changes of CHPs' Function

	Present	Future Changes
Target Population	Problem individual and family	Total population, particularly with high risk groups(individual, family, community)
Role	Service provider consultation and referral	service provider, educator, consultation and referral, community health care worker, health team work promoter, evaluater and researcher, information collection and dissemination
Main activities	Primary therapy prevention of disease	prevention of disease, promotion of health, primary curative care, rehabilitation
Method of approach	Actual demands for medical services partial solving of health problems	team work and comprehensive approach for health and welfare needs of individual, family and community
Target of function	Primary problem solving for individual and family	promotion of health for individual, family and community. promotion of self-care ability, promotion of self-hedlp, self-standing ability
evaluation of practice	Number of services achievements (Output)	coverage of health care problem solving for risk groups, changes in health behaviour, changes in health status: infant, maternal death rates, death rates, birth rates (Effectiveness/Impact)

(2) Promotion of training management

A. Revision of present curricula

The contents should cover the work areas to fulfill the demands in knowledge and skill, therefore, it should be revised as follows; What should be taught to the CHPs? In principle the contents should be changed to be in accord with the changes in their functions, further what the CHPs want to learn should be considered and supported.

To do so, the objectives of training should be clearly defined and the wording for this should be much in detail to accurately reflect the learning needs of the CHPs.

First, Analysis of community health care need,

Second, Job description-list of tasks

Third, Curriculum design

- Teaching and learning objectives
- Teaching methodologies
- Set syllabuses for knowledge, skills, attitudes
- time allocation
- evaluation method

Fourth, Evaluate professional performance following the training

The present 24 week training course with a performance training curricula should be revised and improved to match and fulfill the objectives of primary care and the changes in the CHP functions.

Moreover, the present program is composed by 3 parts, didactic, clinical and local practice. The allocation of time, particularly for the didactic and clinical training, the contents and evaluation should be improved, also the training methods of competency based training should be taught to the team of trainers.

For this, further study will be done using a workshop methodology and including all of the concerned people.

B. Training program to become professional nurses according to the specialty

As far as the duration of the training program for professional nurses according to the Medical Law, there is not much difference between the public health nursing course, home care nursing course and the CHP the didactic courses but the time for practical training is much longer for the CHPs. Also, though public health nursing and home care nursing cases are certified by the government the CHPs only get certificates of course completed, but not a government certification to practice.

The differences between the courses in duration is that the other two courses take a year while the CHP course is only for 24 weeks. It is preferable that the licensing be uniform in that while all of the practitioners have basic nursing licenses. If the first six months of work for the CHPs could be counted as a period of practice plus the original 6 months of study to make a total of one year the time requirements would be the same as for the other two. Through this arrangement, the CHPs could also be certified to practice.

Table 9. Comparison of professional courses

	Public health nurse course Subjects & hours	Mental health nurse course Subjects & hours	Anesthesia nursing course Subjects & hours	Home care nursing course Subjects & hours	CHP Subjects & hours
Didactic	384	200	200	352	312
Practice	120	1,000	1,300	248	704
Total	504	1,200	1,500	600	1,016

Source: Dr. Won Jung Cho, "Redirection of CHP's function and Training Program" paper presented at the evaluation workshop on CHP program, 1991, October

C. The CHP training program was carried out in nine schools at the beginning in 1981 and through 1987. From 1987, three schools were designated to continue the training program as formal training institutes.

Fundings are available for following items only: honorarria, practical training fee, supplies for training and pay for the assistant, but nothing for maintaining the facilities or equipment. Adequate support to these training institutes should also be considered.

Time re-allocation for the didactic or clinical training cources, financial support for the responsible trainers, development of self-learining program packages, creative improvement of the didactic course, clinical practice evaluation tool development and also evaluation of preceptor are urgently required.

Further, additional chronic disease care and health promotion programs for home nursing care are necessary. High-technology care courses should also be developed.

D. Managerial provision in CHP training

The training of CHP at the formally designated training schools as the base in 1991, cost per trainee an average of ₩1,870,000 which was provided. This is not a small amount of money. It is important to consider whether training should be continued in this way under the support of the central government or whether it is possible to charge the trainees. Otherwise, should it be included in the formal nursing education in four year college programs, integrating it so that graduates from these schools could be CHPs with only 6 weeks of additional orientation in the communities. These proposals need to be considered and reviewed.

At present, in two universities, this integration of the formal nursing education and CHP training is being done. The final conclusion as to practicality will come out sometime in January or February 1992.

However, the CHPs, presently have as a special objective service for people who live in the underserved remote areas following the contents of the Special Law as personnel for government programs and study is needed as to whether it is preferable that another permanent personnel category for CHP be developed separately.

4) Improvement of operation of the CHP posts

(1) Premises for improvement

A. Following the set up of an autonomous system in the infrastructural organization, some new policies can be expected in the utilization of CHPs in primary health care services.

B. Sufficient instructions should be made regarding the operation of the CHP posts under a support of health centers. No systematic or clearly defined relationship has existed previously.

C. For the CHPs, it is important to support their professional, independent autonomy at the maximum level, even as they later attain the status of civil servants.

D. To fulfill the health demands of people in the areas, the Medical Law should be amended to legalize the CHPs as professional nurses.

(2) Support system within the county health organization

Health networks include the following: health center, health subcenters, CHP posts and hospitals or clinics. To promote the health status of the population, a coordinating system should be adequately developed, particularly, at the time when the autonomous system is extended down to the county level. The health center would be the center of the network and its role would be as follows:

A. Role of health center

* Regular meetings should be held to carry on good coordination throughout the network, the personnel of health centers, health subcenters, the CHP posts, hospitals and clinics.
* Health education for people should all be done together.
* Preventive programs should be operated by all members.
* Supports should be available for health education material develpment and its program from administrative and financial aspects.

B. Role of hospitals and clinics

* A feedback system should be rationally developed for cases referred from health center and health subcenters as well as the posts.
* Dissemination of new technics and knowledge should be made available for the personnel of the health centers, health subcenters and the posts, and it must be well supported from administrative aspects.
* Overall statistics should be kept by the health center.

C. Role of health subcenters and the posts

* Services for the health care of the population of the community should be jointly developed.
* Health education for the population of the community should be done jointly by the public health doctors, CHPs and health workers in the township.
* Special clinics could be operated in the CHP posts by the public doctors to strengthen the services on treatment and prevention of disease.
* The CHPs health workers should work jointly for health promotion programs and health education also plans and evaluation.

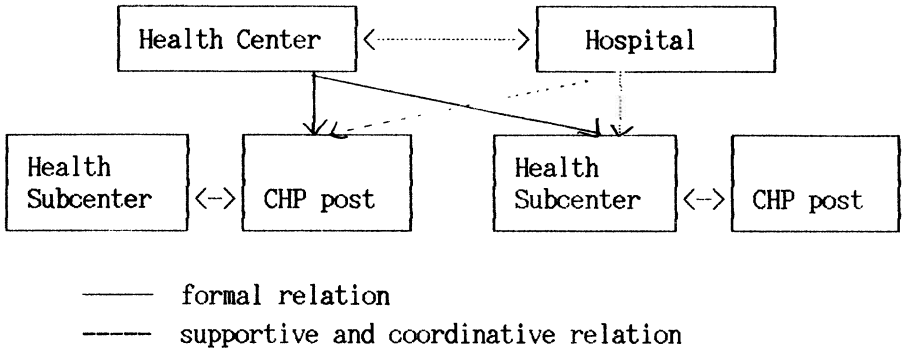

Figure 3. Supporting system

A monitoring system should be developed for the team activities and to do so, the director of the health center should learn monitoring methodology and necessary technics concerned with monitoring, including evaluation, utilization and planning and all member of the team should be concerned with communication and partnership which should be taught for appropriate work among them.

(3) Supervision

Supervision includes administration, education and assisting abilities. Supervision should not only be to order, but also, to teach technics and knowledge to allow personnel to work sufficiently in their own fields. Therefore, supervisory work is never easy in any sense, but how it can be worked out and the way it can be developed effectively is truly complex and also there is always suspicion as to whether it is worthwhile.

Further, supervision is defined as an important matter for personnel development in the administrative process. Supervision is reckoned as administration, education and as a helping process by the supervisor.

The role of supervision is to look after the following: composition of personnel, target setting, communication and coordination within the organization, personnel planning and the provision of role and duty for personnel concerned.

Administrative structure has three importantly related processes; decision making, operation and developing communication channels.

Education should be focused on the promotion of ability of personnel by providing knowledge and understanding of action, regulation and duty of the organization. Task-forced education is important. It includes knowledge and ability education, emotional and practical education also.

From the above, the supervision can be defined as a difficult process to carry on and it would be more so in the case of the CHPs. Nevertheless, to promote quality of services the supervision system should be operated as follows,

A. Supervisor

* To supervise the CHPs' activities in administration and in the aspects of education and helping, a focal person who has had experience as a CHP, has should be employed by the health center to primarily supervise the CHPs.
* The Nurse in the top position among nurses in health center could be utilized as a supervisor.
* At the provincial level, the nurse for the CHP program could act as a supervisor as has been done in the past.

B. Education for Supervisors

* For supervision at the provincial government level or county level, special education should be provided for those who will be in supervisory positions.
* Instruction for supervision should be developed. Regular evaluation meetings are also necessary.
* According to the results of evaluation, the heads of the province and the county office as well as private health institutes, should develop close and efficient coordination to provide administrative support and education and promote the activities of the CHP and utilize them in the future.

General support for improvement of quality follows the system of support already mentioned.

(4) Supply system

As was mentioned in the chapter on the present status of the CHPs, the CHP posts have not actually been included in the health network so far, but rather they here been operating following the Special Law and understood as somehow separate institutes.

There was no clearly developed instruction from the central government to the local officials and so that they differ from county to county according to the local systems.

However, with the develoopment of the autonomous system, the budget for the subsidy can be transferred to the counties. In this situation program planning, operation, budgetting and supplies will have to be done by the county office itself, which will be a much better situation.

Further, when the CHPs become civil servants and formal regular staff of the government the supplies and also evaluation of their work, will not be a problem in the future.

(5) Operating funds for the posts

The operation and managerial funds mostly depend upon the posts' income. The subsidy of the central and local government were nominal. Amounts of ₩300,000 to ₩500,000 are necessary monthly, and these depend on the CHP's work. Problem will arise if they do more work for prevention and less therapeutic work in the future.

However, it is clear that the CHPs should not have to work to provide for the post operation. They should work for the promotion of the health status of population as are the objectives of the post.

The problem of the operating funds can be solved as follows,

A. Following the system used by the health centers and health subcenters, the budget for the posts should be covered by the health centers as it is for the health subcenters.

B. All necessary supplies such as medical equipment and other furniture, maintenance and repair costs should come from the county, but small items such as drug purchases, public expenditure, office supplies, fuel, etc., can be disbursed according to the capacity of the post.

The managing committee of the post can be shifted to a community development body looking after the health status of the community, welfare and various problem evaluations as the CHPs will become of government staff.

(6) Community participation

It was mentioned by the Alma-Ata declaration that "Community participation is the process by which individual and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their and the community's development. They come to know their own situation better and are motivated to slove their common problems." It is important to provide the ability for citizens to take part in community development, and participate in its process.

To promote participation, nothing can be forced, particularly that which is not so familiar. Instead, it is important to help the community to find solutions to problems by themselves through their own way, to let people think and consider the situation and to understand what abilities are necessary to solve the problem and to help them to know something about their community. The CHPs can only assist and discuss their work showing the available figures of other communities for comparison.

To promote participation,

A. Identify problems in the community and prioritize.

B. Plan the primary health care program services, and in the process of its operation, participate sufficiently.

C. Participate by themselves for a healthy life style, nutritional intake, sanitation, improvement of vaccination and health education services, and feel responsibility for positive health services.

D. Community participation in financial support and in supplying resources and physical labour.

Community participation is the supporting body between the government and the communities. It should allow for the exchange of information and also feedback. The government should support these bodies as a necessary liaison and settle the primary health care program in the communities. It should firmly conform to the law, and if necessary, sufficient personnel, material, technical and financial supports should be made available by the government.

Under the above theory, when the CHP posts were installed to deliver primary health care in the communities, the post managing committee and village health volunteers were organized for community participation. These were fully supported by the law as well as administration, however, technical and financial supports were not at all sufficient.

The villagers' participation so far has actively worked to connect health personnel and villagers. They have voluntarily served for information collection, an important role in the community.

These village health workers will work to promote self care ability for the villagers as the agents in the future, and the CHPs should further actively lead and utilize these workers and the autonomous body should support their work financially.

When the autonomous system is activated this will be the authority and duty of people, and the promotion of welfare and naturally health services will be required, and therefore, the participation of villagers will be also activated. The village workers and the committee members will participate more actively than before.

However, the expectation of activation entirely depends upon how the autonomous body itself can be firmly settled, particularly where self supporting conditions are not sufficient and also how the officials operate the health service work to promote the health status of the people concerned.

(7) CHPs as Health Professionals

Article 54 (Nurses in different fields) of the Medical Law showed that the Ministry of Health and Social Affairs can accept other licenses besides the nursing license for special fields and those can be decided by regulation of the Ministry.

According to the article mentioned above, licensing in special fields will be accepted after one year of an extra training courses.

In the case of the CHP, the duration is 24 weeks for the course, but the contents of the didactic or clinical training are sufficient to warrent licensing as professionals. Therefore, the category of the CHP should be included in the Law governing health professionals.

Furthermore, when the status of CHPs changes to that of government staff, some of the CHPs should be promoted as leaders in their counties or provinces.

For the CHPs to become professionals, administratively clearly defined lines of authority, position of title, qualification, detailed tasks and skills should be identified. The opportunity for learning new knowledge and skills, an appropriate environment to maintain professional behavior, appropriate office facilities and adequate pay scale are also necessary.

Ⅳ. Conclusion and Recommendations

1. Conclusion

This study was to review the overall achievements of the CHPs' over 10 years and to identify methods to promote their work in the future.

In 10 years' time, in various fields, socio-economic, disease patterns, medical environment and the government policies, a lot of change has occurred.

To fulfill the study objectives a workshop was held and in the workshop all elements concerning the CHPs' work were shown. The contents of the materials, questionnaires and also the contents of discussion were analyzed. This report, therefore, is written mainly from the outcome of the workshop.

It is certain that the CHP system was positive to the health services of the remote areas showing that it has an important role in providing equal benefit to the underserved populations in the country. Although the working environment and pay scale were not sufficient or satisfactorily provided, the CHPs at the grass root, level continued their work in health services.

In order to promote the health status of the population, the CHP program, should be extended to the urban poor also, and further this system could be utilized in the public health institutions, hospitals, schools and industrial fields in the urban areas.

Following changes in the socio-economic factors, disease patterns and health demands and even in the rural communities, the role of the CHP, education and way of management have to be changed to meet the needs of these environments.

For the promotion of health and of living, self-care ability should be taught.

In conclusion, the following recommendations were accepted by the experts, professors, policy makers and also the CHP themselves after sincere presentations and much discussions.

2. Recommendations

In 90th decade, to promote the health status of the population and welfare services, with the provision of primary health care and for the operation of the CHP system, the following are recommended.

1) Direction of primary health care

* The CHP's work as primary health care providers for the problems of rural remote areas should be extended to fulfill health demands in the prevention of disease and promotion of health, and the health policy should be modified.

* To promote health through the primary health care, health policy development, health environment, health life-style and health infrastructure should be politically implemented at the central, provincial and county level.

* The primary health care should be focused to motivate and educate the entire population in order to make it possible for people themselves, socially and economically, to be more productive and have better lives through self-care.

* Community participation for healthy living and high quality of life should be further strengthened.

* The primary health care program should be covered as an important policy by the central government for the prevention of disease and the promotion of health using comprehensive approaches throughout the country.

* To strengthen the primary health care program, the planning and managerial function of the health centers should be strengthened, and health centers should support the team work in the network concerned.

2) Improvement of the CHP program

(1) Role of CHP

* The role of the CHP should be strengthened and focused to promote health and prevent disease and to identify the risk factors related to health.

* The CHPs should be trained for program planning and operation and evaluation functions to carry out the development of various program and to further community participation. For this a newly developed approach must be found.

* The CHPs should work for MIS and self-reliance attitudes and to develop efficient coordination of various offices.

(2) Training of the CHP

The CHP training in the prevention of disease and promotion of health should be changed to problem solving, time re-allocation for didactic and practice, should be considered creative self-studying methods, should be introduced and evaluation tasks for a practice and precepter system should be introduced.

* For effective CHP training, responsible specialty teams and high-technology teams should be arranged. A national policy of support is required and evaluation of the training institutes is necessary.

* The CHPs should become as professionals like home health care nurses. This must be authorized and the training program modifications should follow.

(3) CHP work and operation of posts

* Even after the CHP's status is changed to civil servants, professional, autonomous and independent work should be maintained keeping in mind that the success of their work is dependent upon these factors.

* The operating cost of the posts should be fully supported by the central government. Also the salary of the CHPs should be subsidized 50% by the central government since self-support from the autonomous body is not yet fully possible.

* The managing committee of the posts should be revised as the health and welfare development body in the community.

* For the improvement of CHP work, continuing training program should be developed, for this, financial support should be given by the central government.

* The utilization of the CHP should be extended to the urban poors and not restricted to the remote rural areas. It should also be extended to public institutions, schools, industrial, or even facilities for the elderly. The CHPs can worked in all aspects of primary health care, and legalistic and administrative support should be made available for their kinds of activities.

References

Arthur Goldsmith & Barbara Pillsburg David Nicholas, Community Organization, Primary Health Care Operations Research, 1985

Ascher J. Segall, M.D., Hannelore Vanderschmidt, Ruanne Burglass, Thomas Frostman, Systematic Course Design for the Health Fields, John wiley & Sons, 1975

Bong Sang Park, etc., Future Dirction for the Health Policy in 90th decade, Korea Institute for Health and Social Affairs, 1990

Carl Heuel, The Supervisor·s Basic Management Guide, McGraw-Hill, 1965

Center for Educationla Development in Health, Boston University, Health Policy Institute, 1979

Community Health Practitioners Post Operation Related to Special Law for Rural Health Care, Chon Buk Province, 1980

Current Status of Community Health Program, Ministry of Health and Social Affairs, Community Health Division, 1991

David B. Smith & Arnold D. Kaluzny, The White Labyrinth, McCutchan Publishing Corporation, 1975

Dorothy E. Pettes, Supervision in Social Work, George Allen & Unwin Ltd., 1967, Division of Macmillan, 1989

Eui Sook Kim, etc., An Activity Analysis and Curriculum Development Study of Community Health Practitioners in Korea, Yonsei University College of Nursing, Seoul, Korea, 1988

Encyclopedia Britannica, INC, Webster's Third New International Dictionary

Greene & Symons-Morton, Introduction to Health Education, Oxford University Press, 1984

Holland, W.W.(Ed.) Evaluation of Health Care, Oxford; Oxford University Press, 1983

Jin Soon Kim, etc., Evaluation of CHPs Post Utilization, Study of Rural Primary Health Care Project, Korea Institute for Population and Health, 1985

Jin Soon Kim, etc., Study on the Community Health Practitioners Post Operation Analysis, Korea Institute for Population and Health, 1987

Jin Soon Kim, etc., Survey of the Actual Situation of Maternal-Child Health and Family Planning in Rural Areas Coverd by Community Health Practitioners, Korea Institute for Population and Health, 1985

J.J. Famularo, Supervisors in Action, McGraw-Hill, 1961

J.J. Guilbert, Educational handbook for health Personnel, World Health Organization, 1981

Korea Health Development Institute, Primary Health Care Demonstration Project in Korea; 1976-1980, 1980.12

Korea Institute for Health and Social Affairs, A Survey on the Improvement of Community Health Practitioners Programmes - summary - , 1991, (Unpublished Paper)

Korea Nurses Association, A Status on Public Health and Medical Service, Publishing Division, 1990

Kun Yong Song, etc., A Study of Health Care in Rural Farm Fishing Vollagers - Basic Survey to Evaluate and Describe the Community Health Practitioner, Korea Institute for Population and Health, 1983

Lorenz K.Y. Ng, & Devra Davz, Strategies for Public Health, Van Nostrand Reinhold, 1981

Martin M. Broadwell, The Supervisor and On-the Job Training, Addison-Wesley, 1975

Moon Sook Suh, 'A Study on the Role Conflicts of the Community Health Practitioners', Master's Thesis, The Graduate School of Health Science and Management, Yonsei University, 1984

Myron E. Weiner, Human Services Management, Wadsworth, 199

Norma L. Chaska, The Nursing Profession: A Time to Speak, McGraw-Hill, 1983

Planning Committee on Health Sector, A Proposal for the 7th 5 Year Plan in Health Sector, 1991 (Unpublished Paper)

Seun Hee Kim, 'A Correlation Study of the Level of Role Perception and Role Performance in Community Health Practitioners', Korean Central J. of Medicine, Vol.43, No.4, 1982

Simon Slavin, An Introduction to Human Services Management, The Haworth Press, 1985

Stephaen Holloway & George Brager, Supervision in the Human Services, A Division of Macmillan, 1989

Stephen M. Shortell, Ph.D. & Arnold D. Kaluzny, Ph.D., Health Care Management, John Wiley, & Sons, 1983

The Ministry of Health and Social Affairs, Republic of Korea, The Rural Health Care Special Law for the CHP, 1980

World Health Organization, A Guide to Curriculum Review for Basic Nursing Education, 1985

World Health Organization, Primary Health Care, Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September, 1978

World Health Organization, Teaching for better Learning, 1980

우리나라 일차보건의료사업과 보건진료원의 역할에 관한 평가웍샵

Evaluation Workshop on Community Health Practitioner Program in Primary Health Care

기간 : 1991년 10월 21일(월)－23일(수)
21－23 October, 1991
장소 : 충남 온양 그랜드 파크호텔
Grand Park Hotel, Onyang, ChoongNam Province

주최 : 한국보건사회연구원(KIHASA)
주관 : 보건사회부(MOHSA)
후원 : 세계보건기구(WHO), 대한간호협회(KNA)

PROGRAM

21 October 1991, Monday

10:00−10:30	Registration
10:30−10:50	**Opening ceremony** Opening remarks : Dal Hyun Chi, President of KIHASA Congratulatory address : Mr. Pil Joon Ahn, Hon. Minister of MOHSA Dr. Julien F.Bertaux, WHO representative, Seoul Dr. Jung Ho Park, President of Korea Nurses Association
10:50−11:00	Coffee break
11:00−12:00	Plenary : Keynote address **"Primary Health Care and Role of Community Health Practitioner(CHP)"** −Role of CHP in changing society− Speaker :Dr. Won Ha Yoo, Director−General, Bureau of Medical Affairs, MOHSA
12:00−13:00	Lunch break
13:00−14:00	Plenary : Special lecture **"Trend of Primary Health Care Implementation in Global Context"** Speaker : Dr. K.S.Lee, Scientist, WHO, Manila
14:00−14:20	Coffee break
14:20−15:00	Plenary : Paper presentation on Topic I **"Achievement of CHPs and Future Utilization"** Chairman : Dr. Hyung Jong Park Dean, School of Public Health, In Je University Speaker : Dr. Mo Im Kim Dean. College of Nursing, Yonsei University
15:00−15:30	Discussions
15:30−16:10	Plenary : Paper presentation on Topic II **"Redirection of CHP's Function and Training Program"** Chairman : Dr. Yeo Shin Hong Professor, Department of Nursing, College of Medicine, Seoul National University Speaker : Dr. Won Jung Cho Professor, College of Nursing, Yonsei University
16:10−16:40	Discussions
16:40−16:50	Coffee break
16:50−17:30	Plenary : Paper presentation on Topic III **"Strategies for improving of CHP's System Operation"** Chairman : Dr. Kun Yong Song Director Health Research Division, KIHASA Speaker : Dr. Jin Soon Kim Senior Fellow, Health Research Division, KIHASA
17:30−18:00	Discussions
19:00	Dinner Reception

22 October 1991, Tuesday

09:00−10:00	Guidelines to Group−work
10:00−18:00	Group−work on **−Future direction of CHPs utilization in PHC** **−Role and function of CHPs and their training program** **−Future direction of CHPs system operation**

23 October 1991, Wednesday

09:00−11:00	Plenary : Presentation on Group−work reports
11:00−12:00	Finalization of Recommendation
12:00−13:00	Closing Remarks