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Readings in Family Planning Management

The Case of Korea

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PREFACE

Up to the recent past, we, somewhat naively have expected dramatic reductions in fertility rates solely through the intervention of national family planning programs. Many continue to believe this in spite of the fact that we have not yet developed a fertility control method which is totally safe and free from any side effects.

It is being gradually accepted, however, that the level of fertility control necessary to attain national goals can be attained only through longer-term wider-ranging programs involving every aspect of human life. In the past, most countries contracted their national efforts on socio-economic development plans with little emphasis on family planning programs. As a result of this and strong programs in the public health area, there were the recent sharp increases in population growth. At the present date, rapid population growth continues to be problematic in most of the countries of the world in spite of the fact that many have national family planning programs. In this regard, one may argue that the control of population growth fertility control should be tightly interwoven with other development programs: health improvement, soico-economic development, industrialization, equal distribution of income, equal educational

opportunity, and the improvement of the status of women. Faced with rapid population increases and the resultant population problems, most developing countries are now supplementing family planning programs with various socio-economic measures in an attempt to curb population increase, which is, after all, a prime factor inhibiting the socio-economic development of many countries. Some of these countries, for lack of better solutions, have been forced to experiment with "beyond family planning" measures which, they know well, may not work to lower their present high population increase rates.

In adopting "beyond family planning" programs, these countries are faced with the difficult task of implementing socio-economic development programs without unduly impinging upon individual human rights and welfare. Under these circumstances, the task of managing family planning programs has become increasing difficult, requiring now the additional skills to balance between the effective executing of the country's socio-economic development plans and the protection of the welfare of individuals as well as implementing both family planning and "beyond family planning" programs.

More than ever, family planning personnel seed to be welltrained in managerial skills. What is required is training and retraining qualified managers in family planning as well as new techniques and new methods for program management.

The present publication is a beginning effort to improve the managerial skills of family planning personnel. We hope that it is quickly replaced by even better efforts, but I feel this is a good beginning and express my sincere gratitude to the authors for their devoted effort. My thanks also go to Miss A. J. Cho and Miss C. H. Lee in the Material Development Division for their assistance.

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PART I

OVER-ALL VIEWS OF THE KOREAN FAMILY PLANNING AND INTEGRATING NEW VILLAGE MOVEMENT

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CHAPTER 1

An Outline and Program Analysis of Korea's National Family Planning Program

To practice family planning means trying to have a desired number of children at the time considered most appropriate. Family planning implies that a couple intentionally undertake to control the number of pregnancies, the frequency of childbirth, and the interval between children. The family planning movement was at first concerned with maternal and child health, improvement of the home economy, and better educational opportunities for individual children rather than with the control of a country's population. Today, however, the significance of family planning lies also in the political and economic sphere and is related to the rapid changes which began after the Second World War. The developing countries of the world, which accommodate two-thirds of the world's population, have yet to achieve balanced development. Poverty and stagnation have

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caused problems not only in the developing countries themselves, but on a worldwide scale. Accordingly, developed countries have expressed concern over the rapid population growth typical of the developing countries. The latter have also begun to exert considerable effort in modernizing their own countries. Part of this effort has focused on demographic factors and has resulted in numerous detailed plans of action and many nationally-organized family planning programs. In implementing family planning programs today, emphasis is typically placed on population policy issues on a national rather than an individual basis. With the rising concern over economic development during the 1960s, family planning was advanced as a means of controlling population growth. As developing countries adopted family planning programs as part of their social and economic development plans, many people were misled to think that a family planning program formed a national population policy in itself. There is, however, an important conceptual difference between population policy and family planning.

According to the United Nations, population policy is.... measures and programmes designed to contribute to the achievement of economic, social, demographic, political and other collective goals through affecting critical demographic variables, namely the size and growth of the population, its geographic distribution(national and international) and its demographic characteristics.....[1] This definition is widely interpreted to include all the measures or programs which attempt to affect major demographic factors.[2] Popu-

1) United Nations Economic and Social Council. Population Commission, *Report of the ad hoc Consultative Group of Experts on Population Policy.* 23 May, 1972. p.6.

2) National Academy of Science. *In Search of Population Policy.* 1974. p.86.

lation policy should include two major elements, influencing policies and responsive policies. Different types of policy approaches are needed to control various aspects of birth, death and migration and to help overcome or reduce the undesirable side effects of population change.[3]

Considering that population responsive policies attempt to deal with the problems which may arise from over-or under-population in connection with such social welfare issues such as food supply, employment, urban problems, the distribution of resources, and the like the United Nations definition seems to be limited essentially to population influencing policy.

A family planning program is one means that a country can adopt to control fertility under the heading of population influencing policy. Family planning programs provide the necessary information and services to those couples who want to control their fertility. Such programs contribute to national development by preventing excessive population growth. Although there is a dispute in academic circles regarding whether family planning is the most effective means of controlling population growth, family planning is now widely accepted by national governments as a realistic method of dealing with this issue. In addition, some countries have adopted family planning on the basis of health or human rights, independent of the program's influence on population growth or development.[4]

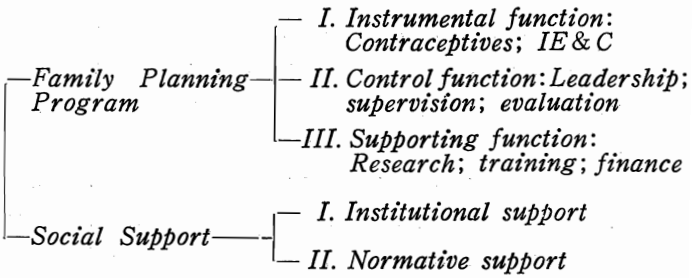
In Korea the family planning program historically emphasized population control as related both to economic

3) National Academy of Science. *Rapid Population Growth.* Johns Hopkins Press. 1971. pp. 70~73.

4) Nortman D. "Population and Family Planning Program: A Factbook", *Reports on Population/ Family Planning.* No. 2. (5th ed.). September, 1973. pp. 34~44.

development on a national basis and to the improvement of individual and family welfare. Government population policy has relied almost entirely upon family planning. Accordingly, this paper concentrates on an analysis of the family planning program which forms the basic means of government intervention for reducing fertility in Korea. In view of the fact that family planning involves various socia land cultural conditions as well as financial and other available resources, analysis is very complex. To simplify the discussion, the family planning program may be viewed as a system composed of several distinct sub-systems. Schematically the program may be considered in the following way:

An Outline of the System Approach for the Analysis of Family Planning



This paper analyzes each of the above functional sub-systems and attempts to explore solutions to various programmatic problems by considering them from the point of social support policies. The overall aim, of course, is to promote effective performance of the national family planning program in the future.

AN OUTLINE OF KOREA'S NATIONAL FAMILY PLANNING PROGRAM

Background and Organization

Korea's family planning program was initiated in the early 1960s as part of the government's population influencing policy. Before 1960 there was no concern with a population problem among senior government officials. Family planning was, however, recognized as an element of the women's movement and as a factor in maternal and child health. Thus, family planning programs were sporadically implemented by non-governmental agencies, academic research organizations and American missionaries during the 1950s.[5] Family planning first became an explicit issue in the national economic development plan of the Korean government after the military revolution in 1961.

Because of a growing understanding of the important relationship between population growth and national social and economic development, the Supreme Council on National Reconstruction (SCNR) decided to adopt family planning as a national policy in November 1961.

Program implementation by the government begun in 1962.[6] The Ministry of Health and Social Affairs, as the implementing agency, undertook the necessary organization restructuring to initiate a full scale program with a goal of reducing the population growth rate from 2.9 percent to 2.5 percent during the First Five-Year Economic Devel-

5) Planned Parenthood Federation of Korea. *10 Year History of the Korean Family Planning Program.* 1975. p.654.

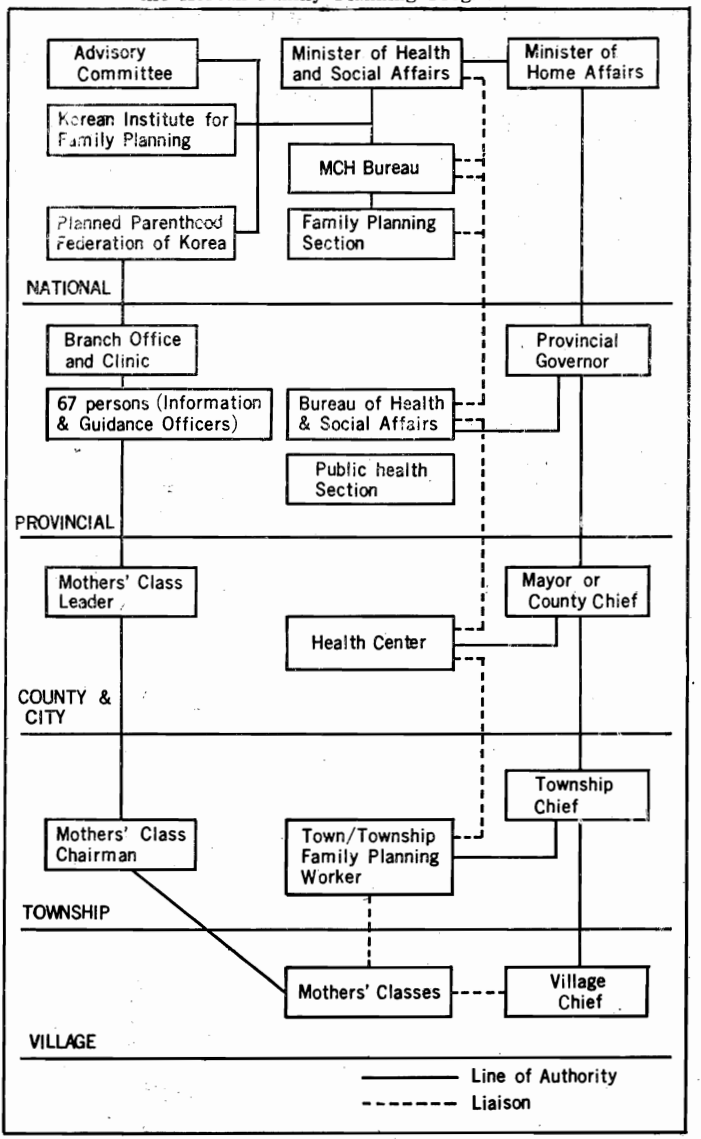
6) Kim, T. I., Ross, J. A. and Worth, G. C., *The Korean National Family Planning Program.* The Population Council. 1972. pp. 44~49.

opment Plan (1961~1966), and to further reduce the growth rate to 2.0 percent at the end of the Second Five-Year Plan (1967~1971). Family planning consultation rooms were added to the existing government health centers in 100 cities and counties throughout the country in March 1962. Staff were assigned to provide vasectomy, condom, jelly, foam tablet, and other contraceptives. In May 1962, consultation rooms were established in 82 new health centers and in the headquarters of the National Reconstruction Movement. All together 183 family planning consultation rooms were established in health centers. Newly recruited midwives and nurses were employed to reinforce program operations. However, the program had vulnerable aspects as there was no infra-structure at or below the county level.

In December 1963, the Government reorganized the program's structure by establishing a Maternal and Child Health Section in the Ministry of Health and Social Affairs to implement both the maternal and child health and family planning programs. In 1964, the Ministry assigned a family planning fieldworker to each of the 1,473 Eup (township) and Myon (county) offices. Field workers performed educational activities, delivered contraceptives, made home visits and provided group guidance. In order to supervise field workers, a family planning sub-section was established within the Public Health Section of each special city and provincial government. This provided a basic structure for the implementation of the national program. With the expanded organization, the Government in 1964 added IUDs to the list of available contraceptive methods.

The Planned Parenthood Federation of Korea (PPFK) was established in 1961 as a non-governmental organization.

Figure 1. Organizational Structure of the Korean Family Planning Program



Source : Korean Institute for Family Planning. Korean Family Planning Program in Charts. Sixth Edition. 1975.

PPFK undertook IE & C activities and training programs in close cooperation with the Ministry of Health and Social Affairs. In 1968, PPFK organized Mothers' Clubs in villages throughout the country to support the family planning program. In order to overcome problems resulting from the high drop-out rate of IUD acceptors, the government made oral contraceptives available through program channels in 1968. With the completion of the program's operational structure through the health network and the Planned Parenthood Federation, a family planning evaluation unit was established in the Maternal and Child Health Section of the Ministry to measure the program's progress and provide information on program operation.

By 1970 the family planning evaluation unit developed into the National Family Planning Center. The National Family Planning Center had responsibility for evaluation, research, and training activities which had been previously carried out by the Planned Parenthood Federation. In order to provide an objective posture and maintain professional staff, the Center was reorganized in 1971 into a semi-governmental body and renamed the Korean Institute for Family Planning (KIFP). Figure 1 presents the program's operational structure as it is at present.

As described earlier, oral contraceptives, condoms, sterilization services, and IUDs were introduced into the national program at different times. In the early stages of the program (1962~1963), only traditional contraceptives, such as jelly, diaphragms, foam tablets, and condoms were provided by the government. Special emphasis was also given to the rhythm method. After several clinical studies, the lippes loop was introduced into the program in 1964. Subsequently the provision of other contraceptives except the

condom was stopped. In 1968, oral pills were added to the program. Later, female sterilization was to form a major thrust in the program.

The Korean national family planning program is implemented through family planning field workers based in health centers. These workers emphasize the delivery of contraceptives. This program is currently carried out through 198 health centers with 2,533 field workers. Another important aspect of the national family planning program is the target system. Family planning acceptor targets are distributed to the two special cities of Seoul and Busan and the nine provinces in accordance with geographic preferences for each contraceptive method, the number of fecund women, the existing practice rate among the target female population, and the level of use of the government health network, by eligible women. The targets are further allocated to cities, counties and district health centers. Acceptors allocated to health centers are recruited directly or indirectly by family planning field workers. The Mothers' Clubs organized throughout the country also actively participate in the program within their communities by helping the family planning field workers.

Hospital-based family planning was introduced in 1974. A total of 74 public and private hospitals was designated to provide family planning services by employing family planning field workers to motivate potential acceptors. Ten urban family planning clinics were established in Seoul in 1974 to provide family planning services to the needy population in urban areas. Two new urban clinics were opened in Busan in 1976. This program will soon be expanded to other cities.

In addition to the above mentioned organizations, the

Central Office for Population Education was established in the Ministry of Education in 1974 to provide population education in schools. In early 1976, a Population Policy Deliberation Committee was established under the chairmanship of the Deputy Prime Minister to provide leadership in developing a comprehensive national population policy. In addition, enormous contributions have been made by external organizations supporting population related work in Korea. The major donor agencies have included the Population Council, USAID, IPPF, SIDA and UNFPA. The last has provided the greatest portion ef external assistance since 1974.

Program Achievements

DELIVERY OF FAMILY PLANNING SERVICES

The National Family Planning Program currently provides the following contraceptive methods : condoms, oral pills, IUDs and sterilization. As shown in Table 1, condoms have been provided from the earliest stage of the program. Since 1964 more than 150, 000 persons per month have received condoms through government channels. Sterilization services have focused on vasectomy with an annual average of 20, 000 acceptors in recent years.

The IUD, introduced into the program in 1964, was used by about 400, 000 women by 1966.

Oral pills, introduced in 1968, have been accepted by an average of 200, 000 women each year.

A recent review of the delivery of contraceptives indicates that about 838, 000 persons, 19 percent of the total of 4. 5 million eligible couples (those aged 20~44), benefited from the government's family planning program in 1975.

Table 1. Program Achievement by Year (1962~1975)

	1962	1963	1964	1965
IUD	—	1,493	106,397	225,951
Sterilization	3,413	19,866	26,256	12,855
Oral pill	—	—	—	—
Condom	—	129,804	156,301	192,706
Total	3,413	151,163	288,954	430,512

	1966	1967	1968	1969
IUD	388,911	320,578	263,142	285,500
Sterilization	19,942	19,677	14,988	15,457
Oral pill	—	—	26,264	91,111
Condom	168,868	138,425	134,388	147,795
Total	577,721	478,680	439,782	539,863

	1970	1971	1972	1973
IUD	295,100	293,792	300,309	325,935
Sterilization	17,321	18,581	19,698	24,492
Oral pill	170,518	199,325	213,948	234,698
Condom	162,733	161,346	155,605	176,032
Total	645,672	673,044	689,560	761,157

	1974	1975	Total
IUD	349,509	343,858	3,500,475
Sterilization	34,627	57,588	305,761
Oral pill	241,976	240,191	1,418,031
Condom	172,688	196,735	2,092,426
Total	798,800	838,372	7,316,693

IUDs were used by 344,000 persons and sterilization was accepted by 57,600 persons, among whom 74.2 percent accepted vasectomy. Compared with 1974 achievement,

the acceptance rate for vasectomy rose by 44.4 percent.[7] This increase in sterilization is attributable to rising acceptance by women who have been using IUDs or oral pills and are now ready to permanently end the risk of pregnancy. Motivation for the male population to accept vasectomy has come through street campaigns and lectures to reserve force training groups. In the case of the oral pill, there is a monthly average of approximately 240,000 users, 96.6 percent of whom are continuing acceptors. The acceptance rate for oral pills rose continuously from 1968 to 1974 after which it leveled off. A monthly average of 197,000 persons used the condom in 1975, an increase of 13.9 percent since 1974. Condoms are widely accepted by younger couples and are increasing in popularity. It is thought that the improved quality of condoms and new packaging have prompted the upswing in acceptance. Program statistics for the period 1962~1975 indicate there were about 3.5 million IUD acceptors, 306,000 acceptors of sterilization, 1,418,000 oral pill acceptors, and 2,092,000 condom acceptors, thus totalling 7,317,000 acceptors under the program.

It is estimated that 3,020,000 births have been averted by the national family planning program. IUD use has prevented 1,490,000 births, the condom has prevented 650,000 births, and sterilization and oral pills have together prevented a total of 440,000 births.[8] This relatively low contribution made by the oral pill is due to the fact it was introduced into the program later than the condom and IUD.

7) Korean Institute for Family Planning. *1975 Family Planning Program Evaluation Based on Service Statistics.* 1976. p.9.

8) Korean Institute for Family Planning. *Achievement of the National Family Planning Program by Health Center Based on C.Y.P.*, 1975.

KNOWLEDGE AND PRACTICE OF FAMILY PLANNING

KAP surveys which have been conducted on a regula basis since 1964 reveal a growth of knowledge and acceptance of family planning among the population. About 98 percent of all eligible couples were aware of more than one method of contraception in 1973. This high rate of knowledge about family planning does not necessarily imply that all targets can be achieved by the program. Although knowledge should be provided to potential acceptors in the motivation process, knowledge itself does not greatly affect the decision making process. The goal of the family planning program is to reduce fertility. Increases in knowledge alone cannot meet this goal. Much progress has also been made in attitudinal and behavioral change. Approval of family planning reached 89 percent in 1965 among the eligible female population. Approval increased further to 96 percent in 1973.[9] Unfortunately, the practice rate is much lower than knowledge and approval rates. In 1973, 36 percent of all married women aged 15 to 44 practiced family planning. The practice rate varies as indicated in Table 2. About 39 percent of women in urban areas were using contraceptives while 34 percent of those in rural areas were doing so. The practice rate gradually increased from 9 percent in 1964 to 16 percent in 1965, to 20 percent in 1966~

9) Koh, K. S. "Analysis on Family Planning and Information, Education and Communication," *Report of Special Analysis on 1973 Korean Fertility and Family Planning Survey*. Korean Institute for Family Planning. 1974. p.26.

1967, and to 25 percent in 1971. Although accurate data on the practice rate is not yet available for 1976, it is estimated from the 1974 Korean National Fertility Survey that the practice rate at the end of the Third Five-Year Economic Development Plan (1972~1976) is in the range of 43~46 percent.

Table 2. Family Planning Practice Rate among Eligible Women (Married Women Aged 15~44)

Area	1964	1965	1966	1967	1971	1973
Whole country	9%	16%	20%	20%	25%	36%
Urban	19	21	26	26	27	39
Rural	6	14	18	17	23	34

Source: Family Planning Evaluation Surveys. Korean Institute for Family Planning. 1964~1973.

Change in Fertility

The demographic effect of the family planning program can be measured by the changing level of fertility. The total fertility rate (TFR) in Korea was 4.1 in 1972~1973. This represents a remarkable decline when compared with a TFR of 6.3 in 1960. On average, a woman had 6.3 children during her reproductive period at the begining of the national family planning program. This figure had declined by over two children in the first dozen years of the program. The TFR is estimated to be approximately 3.5 in 1976. The age-specific fertility rate for women aged 25~29 is currently about 300 per 1,000. For women above age 30, the fertility rate has declined significantly since the inception of the family planning program. Fertility among women aged 20~24 also declined greatly during 1970~1973

period.[10] The age-specific fertility pattern of Korean women in 1972 was similar to that of Taiwan and Singapore. However, the Korean age-specific fertility rate of 327 for women aged 25~29 is considerably higher than the 219 rate of Singapore.[11]

Although fertility in Taiwan for the age group below 25 is higher than that of Korea, the rate for the age group 25~29 is higher in Korea than Taiwan.[12] This phenomenon is believed to be caused by differences in the age at first marriage. Taiwan has had a lower total fertility rate than Korea. Taiwan's rate was 3.4 in 1972 while Korea's was 4.1 in 1973. Taiwan had already lowered its general fertility rate to 104 per 1,000 women compared with Korea's 117 per 1,000 women in 1972. Considering the above facts, it must be pointed out that Korea should make further efforts to reduce fertility by means of an institutional support program as well as by means of the existing program of family planning.

Problems in the Program

Many problems have been encountered in the implementation of the family planning program. Most important is the existence of a "baby boom" generation.[13]

10) Moon, H. S. "Fertility Estimation", *Report of Special Analysis on 1973 Korean Fertility and Family Planning Survey.* Korean Institute for Family Planning. 1974. pp. 49~52.

11) Population Council. *Studies in Family Planning.* Vol. 5, No. 5. East-Asia Review. 1973, p. 163.

12) Population Council. *Studies in Family Planning.* Vol. 5, No. 9. Trends in Fertility, Family Size Preferences and Practice of Family Planning. Taiwan. 1965~1973.

13) Kwon, T.H., et al. *The Population of Korea.* The Population and Development Study Center. Seoul National University. 1975. p. 118.

The post-war baby boom generation, born in the 1950s after the Korean war, are now entering their reproductive period. Their fertility itself may not pose a serious problem, but it is obvious that the increasing number of women in the reproductive population will cause an overall birth rate increase which will be a detrimental factor in reducting the growth rate. Secondly, we must evaluate the contribution of a high female age at marriage in the reduction of the growth rate. According to survey data[14] the mean age at first marriage in 1944 was 16. Age at marriage rose to 22.5 in 1965. By 1974 the age at marriage was 23.[15] Rural-urban differences have been small. The age at marriage for women in urban areas was 23.2 and for women in rural areas it was 22.2 during 1970~1973. As the average age of first marriage among the female population has reached an upper limit, we cannot expect a further contribution to be made by this factor in reducing the growth rate. Thirdly, induced abortion has helped lower fertility. The increasing number of induced abortions helped to limit the population growth. However, heavy reliance on abortion is a matter to be carefully reviewed from the maternal health point of view.[16]

In 1963, the induced abortion rate was 5 per 1,000 women. It increased to 12 per 1,000 in 1973.[17] There is no need to say that the increasing utilization of abortion has

14) Song, K. Y. and Han, S. H., *1973 Korea Fertility and Family Planning Survey Report.* Korean Institute for Family Planning. 1974.

15) Tentative Estimation from the 1974 World Fertility Survey. Korean Institute for Family Planning.

16) Hong, S. B., Watson, W. B., The Role of Induced Abortion in Fertility Control in Korea. Mimeo. May, 1972.

17) Estimation by Dr. Walter B. Watson based on 1971 Survey Data, Korean Institute for Family Planning.

contributed to the reduction of the rapid rate of population growth. For both social and maternal health reasons, legalization of induced abortion was needed in Korea. In August 1973, the maternal and child health law was revised to legalize induced abortion for medical or psychological reasons.[18] However, many people agree that repeated induced abortions are not advisable. While recognizing the impact of induced abortion on fertility, one must not that abortion is not considered to be the most suitable method for fertility control in a national family planning program. It is much more desirable to promote contraceptive use rather than encourage induced abortion. Induced abortion should be considered only in the case of contraceptive failure. It is thought by some that induced abortion for economic reasons should be legalized. While this position has merit, it is most desirable to reduce the induced abortion rate by maximizing the practice of effective methods of contraception.

It should also be pointed out that there are serious problems related to the traditional norm of son preference and large ideal family size. The ideal number of children for married women in the age group of 15~44 was 3.1 in 1973,[19] a high level when compared with that found in the developed countries. The preference for sons over daughters is about 2 : 1. Thus, there are problems of having more than the ideal number of children to achieve the ideal number of sons. The ideal number of sons in rural areas is higher than that of urban areas. Nationwide, the

18) Ministry of Health and Social Affairs. Maternal and Child Health Law. Seoul, Korea. 1973.

19) 1965~1973 National Survey Data. Korean Institute for Family Planning.

ideal number of sons was 1.9 in 1973, but 1.8 in urban areas and 2.1 in rural areas. As a whole, 70 percent of all eligible women said two was the ideal number of male children.[20] As long as son preference and large family size norms exist among the population, further fertility reduction may not be successful through the family planning program alone. Social and institutional policies should be developed beyond family planning to help deal with these problems.

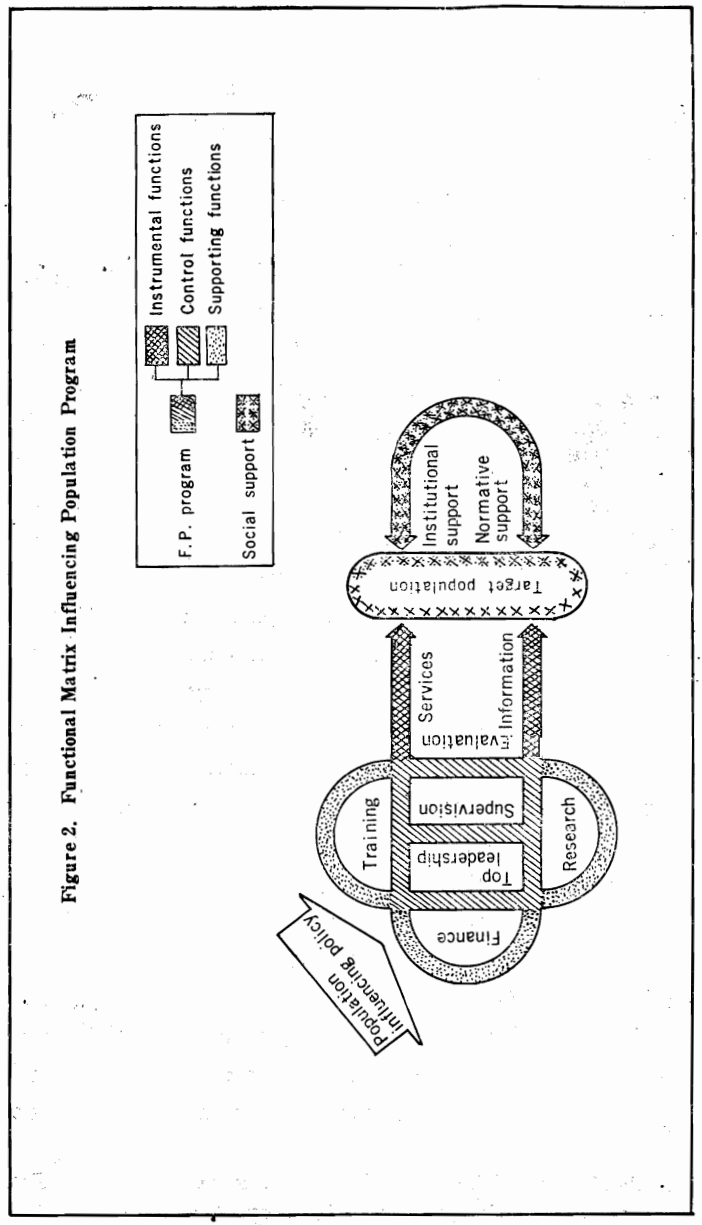
FUNCTIONAL ANALYSIS OF THE NATIONAL FAMILY PLANNING PROGRAM

Since the inception of the family planning program in Korea, evaluation has been carried out by placing stress on service statistics, coupon analysis, and the assessment of changes in fertility and contraceptive use based on national family planning and fertility surveys. However, much of this evaluation has been conducted without a comprehensive and systematic attempt to improve the operation of program.

Considering the fact that the same evaluation pattern has been followed for the past ten years without any significant consideration for the numerous social, economic and cultural changes that have taken place, we feel that the examination of the present family planning program from a new perspective must be carried out. Because of the unfavorable socio-demographic factors that we anticipate will adversely affect program success during the Fourth Five-Year Plan period from 1977 to 1981, it is imperative that new methods of evaluation of the existing family

20) Song, K. Y., and Han, S. H., op. cit., p.39.

Figure 2. Functional Matrix Influencing Population Program



planning program be carried out to help reduce the rate of fertility and population growth.

We have already attempted to examine each function of the family planning program to help outline the program's most important future directions. As the following model suggests, the major functions of the program can be divided into three categories.[21]

First are instrumental functions which cover contraceptive services and information activities; second are control functions, which include leadership, program supervision and evaluation activities; third are the various supporting functions such as training, research activities and financial support. The purpose of contraceptive service and information activities is to provide services and motivation directly to the target population to encourage the widespread use of contraception. For the maximum effect of the control function in the family planning program, decision makers' continuous interest and leadership are required. Adequate supervision must exist at every level from the central government to the gress-roots level where field activities are conducted. Regular evaluation also plays an important part in the control function suggesting future policy directions after assessing the progress, achievements and problems of the program. An essential supporting function is training, which conveys to family planning field workers and other program staff the latest knowledge and techniques needed for field activities. Another integral part of the supporting function are research activities, which should contribute new approaches and directions and back up more advanced and innovative program implementation.

21) Berelson and Others. *Family Planning and Population Program.* University of Chicago. 1965. pp. 321~334.

Finance is also an important aspect of the supporting function. Efficient implementation of the family planning program is not likely to be sustained without the proper financial support.

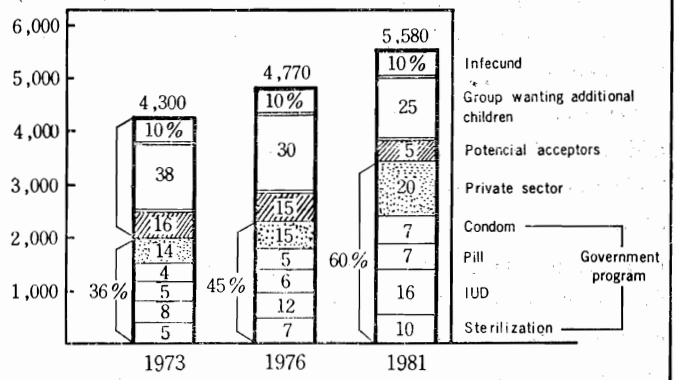
We have made a modification of Freyman's model to add a social support function to fit the Korean program. This change was necessary because widespread acceptance of fertility control is very difficult without changes in traditional norms and customs. The goal of maximizing family planning effectiveness can only be attained in the context of small family-size norms and when the program is systematically conducted and various aspects are well harmonized. Each function of program-contraceptive services, information, supervision, leadership, evaluation, training, research and financial support-depend not only institutional support but also on normative support.

Problem areas and recommendations for the program have been made by carefully examining the present and past family planning programs in the context of the model presented above.

Contraceptive Services

In order to attain the target rate of population increase of 1.6 percent per year by 1981, the last year of the Fourth Five-Year Economic Development Plan, acceptors in all categories must be increased from an estimated 45 percent of all eligible women at the end of 1976 to 60 percent at the end of the Five-Year Plan period. The family planning practice rate among eligible women in the recent past and at present as well as the target level for 1981 is shown in Figure 3. Among the 64 percent of the women who were not practicing, 10 percent were sub-fecund, 38 percent

Figure 3. Estimated Family Planning Practice Required to by 1981



wanted additional children, while 16 percent wanted no additional children. Examining the distribution of the target group of eligible women in 1981, 10 percent will be sub-fecund, the same as 1973. The group wanting additional children is estimated to be 25 percent, a little lower than 1973. The potential target group in 1981 is estimated to be 65 percent of all eligible women (excluding the 25 percent who will want additional children and the 10 percent who are sub-fecund). This target calls for a two-thirds reduction in the proportion of non-practicing women who do not want additional children, from 16 to 5 percent. This implies a significantly higher acceptance rate than has been recorded in past years and will demand a stepped-up effort to increase the practice rate.

The following programs must be carefully conducted in order to attain the target practice rate by 1981. Every effort must be made to maintain high continuation rates by providing quality service utilizing effective contraceptive methods having few side-effects, and to provide adequate medical and personal follow-up services. Contraceptive dis-

tribution networks must be extended considerably to make all contraceptive methods available to all potential acceptors. The following suggestions are made to improve the current status of contraceptive services.

During the past 14 years, a total of 7,390,000 persons have received contraceptive services supported by government program. However, comparatively low continuation rates have been observed with approximately one person out of seven successfully practicing birth control throughout the period. The total number of women exposed to contraceptive services as well as the rate of contraceptive practice has increased remarkably since 1962. (see Tables 3 and 4) On the other hand, new acceptors as a proportion of women who have ever used contraception decreased from 75 percent in 1962 to 66 percent in 1973. This implies that the continuation rate has gradually decreased in comparison to its level at the beginning of the program. Furthermore, it is expected that there will be a greater number of drop-outs as the program expands in the future. Approximately 43 percent of all IUD acceptors and 61 percent of oral pill acceptors have dropped out within six months. These high discontinuation rate have been caused mainly by medical side-effects. Looking over the trends of current acceptors, the IUD and oral pill, which had shown a startling increase during the early stage of their use, have leveled off in recent years, while sterilization, condom and other methods have increased in popularity.

The discontinuation rate in Korea is above that of Taiwan and much higher rate than that of the United States and other developed countries. One of our major concerns is low continuation.

In order to obtain a more widespread use of contracep-

Tale 3. Practice Rate and Ever Use of Contraception by Year

Year	Ever-use of contraception (1)	Practice rate (2)	Index (2/1)
1962	12%	9%	75%
1967	27	20	72
1973	54	36	66

Source: *1973 National Fertility and Family Planning Survey Report.* Korean Institute for Family Planning. 1974.

Table 4. Contraceptive Practice Rate by Year

Method	1966	1971	1973
IUD	9%	7%	8%
Oral pill	1	7	8
Sterilization	2	3	5
Condom	3	3	6
Other methods	5	4	9
Total	20	25	36

Source: *1973 National Fertility and Family Planning Survey Report.* Korean Institute for Family Planning. 1974.

tives and to reduce the high termination rate in Korea, the present target system must be modified. The government program has been dependent upon essentially the same target system since the program's inception in 1962. Targets have been set and allocated by method in proportion to the number of eligible women in each city and province, but without careful consideration for the method preferences of potential acceptors and the geographical characteristics of each area. As a result, the system has caused problems of early drop-outs and poor statistical reporting.

We believe the target system should be revised by introducing a weighted credit system for family planning targets.

The main purpose of such a system is to allocate overall targets by computing a numerical score on the basis of couple-years' protection so as to supply and distribute available methods of contraception in a way that meets the preferences and characteristics of potential acceptors. A feasibility study of the weighted credit system for family planning targets was conducted by Korean Institute for Family Planning in Chungnam Province in 1975. The results of this study indicated that the weighted credit system would be a major improvement over the present method of target allocation.[22]

The clinic service charge for physicians must also be increased. It is impossible to provide either quality clinic service or follow-up care to clients with the present payment scheme of approximately one dollar for an IUD insertion and 7 dollars for a sterilization. Rumors relating to side effects of contraceptive methods are troublesome because they spread more quickly than those related to genaral medicine. Moreover, the degree of exaggeration is much greater with contraceptives. Consequently, maintaining high continuation rates by providing quality follow-up service is more important than simple obtaining new acceptors.

A system for charging a nominal fee for condoms and IUD insertions is timely and desirable. Family planning field workers' loose handling of condom supplies is attributable largely to the present system of supplying condoms at no charge. A demonstration project to study the feasibility of charging for condoms has been begun in both Chungwon County and Chungju City in Chungbuk Province. A pack of (6) condoms costs 30 Won (about 6 cents) in this pro-

22) Korean Institute for Family Planning. *1975 Family Planning Evaluation Report.* Mimeo. 1976.

ject. According to the data shown in Table 5, only 57 percent of the 1975 level was supplied to potential acceptors when a nominal fee was charged. Thus, it may be concluded that field workers are inefficiently distributing large numbers of condoms because no charge is collected nor effective accounting made.

Table 5. Average Monthly Condom Supply in Demonstration Project Area

Area	Achievements (May-Sept.)*		Percentage (76/75)
	1975	1976	
Chungju city	1,115	799	72
Chungwon county	1,470	676	46
Total	2,585	1,475	57

*Achievements are expressed as an average per month.

A preliminary evaluation of the project has shown the following:

1) a very positive response was received from the majority of users to charging 30 Won per pack of condoms; 2) in a managerial sense, this system can prevent abuse and loss of supply since acceptors have to pay; 3) a survey carried out in conjunction with the project revealed that condom targets have been greater than local requirements suggest are appropriate.

On the basis of this study, charging for condom supplies seems most appropriate. In addition, it appears that the proper level of condom requirements will be about two-thirds of the present target when the new system becomes effective. A nominal fee should also be collected in the case of loop insertion. The money collected can be appropriated for such purposes as the preliminary physical examination charge. We believe that a system of modest payments will overcome the numerous problems generated

by the free distribution system. In addition, such a system may reduce the discontinuation rate given users' perception that services they pay for are to be more highly valued than those received free-of-charge.

It is well understood that the goal of a successful family planning program can not be attained without adequate contraceptive service channels, even if knowledge and attitudes toward contraception are favorable among potential acceptors. In Korea, most contraceptive services have been made available through the government's city and county health centers.

Family planning IE & C activity and contraceptive services to potential target groups are provided by approximately 2,700 family planning workers in city and county health centers and town and township health sub-centers. Mothers' Club members also play an important role in helping family planning workers as grass root level motivators. Sterilization and other clinical services such as IUD insertions are performed by 1,500 designated family planning physicians. However, it is impossible at present to provide adequate clinical services because of the tremendous increase in the target population, and the fact that clinic facilities tend to be concentrated in urban areas. With support from the UNFPA, the government has conducted a series of hospital and urban slum area family planning projects since 1974. These projects were not planned to encourage the widespread use of contraceptives throughout Korea. They were designed to provide family planning services to the limited category of urban middle and lower class people. Expansion of the contraceptive service network to these groups is necessary in order to increase the contraceptive acceptance rate. This is so because the contraceptive acceptance rate is sensitive

to clinic density.

The following recommendations can also be made for improving contraceptive service networks. A strategy should be established to make all medical resources, such as hospitals and clinics, available for all kinds of family planning services. In order to increase acceptors through the private sector the present system of supplying IUDs and insertions to only 1,500 designated physicians should be expanded to include all private clinics. Expansion of the contraceptive supply network by encouraging the utilization of commercial channels is also desirable in order to increase the number of self-supporting acceptors. At present, one-third of all contraceptive acceptors in Korea pay for services. It is, however, expected that the number of self-supporting acceptors will increase greatly due to the continuation of rapid urbanization and accelerated economic growth in the future.

In supplying contraceptives such as oral pills and condoms, government support for tax reduction and subsidies to pharmaceutical companies is needed in order to increase the supply of low priced, high quality contraceptives through commercial channels.

A plan for better utilization of family planning workers is also required. Over 50 percent of the potential target population do not have proper contact or communication with family planning field workers. Field workers' heavy work loads, large target populations, broad areas of coverage and the activity adjustment required by rapid urbanization are among the problems that must be faced. Therefore, a new scheme to increase the efficient utilization of family planning workers should be developed to overcome these difficulties.

Considerations in the efficient utilization of family planning workers are:

a) Present activities of family planning workers must be adjusted to meet the characteristics of each geographical region. Especially in rural areas, voluntary community leaders' participation, for example through Mothers' Clubs, in distributing contraceptives and helping with IE & C activity through interpersonal communication is urgently needed. Family planning workers can back up local personnel as rear line coordinators more positively than has been done in the past. The same is true in urban areas. New means of delivering services should be developed specifically for urban slum areas and industrial sites. It is necessary to make every effort to encourage urban middle class couples to practice contraception on a self-supporting basis to the extent they can afford to do so.

b) Currently one family planning worker is placed in each township throughout Korea. However, in order to promote more efficient management and better staff utilization the present system should be adjusted and field workers assigned in proportion to the area covered and the size of the target population. New ways of conducting IE & C activities among eligible couples must also be tried in order to attain the goal of more widespread use of contraceptives. Centralized group activity at each health center may be effective. Field workers should also have the opportunity to learn the latest techniques needed for group activity and cooperation.

c) In an effort to strenghten the performance of field workers, introduction of a bonus system may be an important improvement over the current practice. At a minimum, the present incentive system for sterilizations in Korea must

be replaced by a bonus system. Such a system has been very successful in Taiwan and deserves to be tried in Korea.

Information, Education & Communication Activity

In order to improve knowledge, attitudes and practices (KAP) in the Korean family planning program, IE & C activities have been conducted in a variety of ways, utilizing both interpersonal channels and mass media. Interpersonal communication as carried out by family planning workers and Mothers' Club members has been relatively successful. The Planned Parenthood Federation of Korea has contributed a great deal through the mass media to the public's understanding of the family planning program. According to the 1973 Fertility and Family Planning Survey, 98 percent of all eligible women understood at least one contraceptive method in comparison with only 65 percent in 1965. Approval of family planning was also very high in 1973.

However, a large gap still exists between those who understand and approve and those who actually practice family planning. The family planning practice rate in 1973 was only 36 percent of all eligible women. Future IE & C activity must be conducted with greater emphasis on the behavioral change of potential acceptors. According to a study made by Everett Rogers,[23] at the decision-making stage, interpersonal communication is much more effective than mass communication, particularly in developing countries. Despite these problems, improved IE & C activities are vital for behavioral change. The development of new uses for mass media in

23) Rogers, E. M. and F. F. Shoemaker. *Communication of Innovation.* New York. The Free Press. 1971.

conjunction with more effective utilization of both mass media and interpersonal communication is essential. The employment of various media may be more effective in a group context than either media or person-to-person communication used alone because members may be influenced by group pressure in situations where behavioral change has already been suggested by the media.

It is regrettable that because of a lack of proper IE & C activities a large segment of the public does not know where contraceptive services are available. Strengthened IE & C activities must be conducted to meet the specific needs and characteristics of target groups of eligible couples.

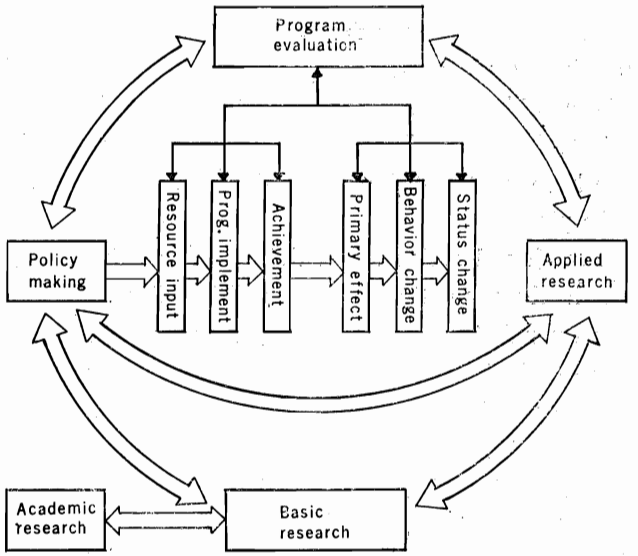
Research and Evaluation

The Korean Institute for Family Planning is responsible for conducting research and evaluation activities in support of the government's population program. The population and family planning, related research and evaluation projects which have been carried out at the Korean Institute for Family Planning, other institutes and universities have contributed a great deal to the improvement of the program.

Research and evaluation activities are an integral part of both the supporting and control functions of Korea's overall population program. Research and evaluation work can be divided into three major types of studies: basic research, applied research and program evaluation. Basic research provides fundamental new ideas for program development. Applied research aims at the development of existing knowledge, while program evaluation is concerned with all operational processes from policy formulation to the measurement of the effectiveness of program implementation.

Such work is an important part of the control function of the population program. It covers problem identification, solutions to problems of program implementation, assessment of programs aimed at knowledge, attitude and behavioral change as well as overall evaluation of changes in fertility and social welfare due to family planning practice. A successful family planning program can not sustain itself without each process and function shown in Figure 4. However, much of this work has been concentrated in limited areas defined by the interests of Korean researchers. Duplication in some areas and a lack of work in others has been apparent. As illustrated in Table 6, the direction of research and evaluation activities can be categorized

Figure 4. Research and Evaluation System



into five major fields:

1) the provision of contraceptives and induced abortion; 2) information and education; 3) training; 4) organizational research; and 5) social and economic policies.

Table 6. Proposed Direction of Research and Evaluation Activities

Research field	Basic research	Applied research	Evaluation
Provision of contraceptives and induced abortion	-Reproductive physiology	-Acceptability of contraceptives -Adoption and use of contraceptives -Effectiveness and use efficiency -Channels of contraceptive distribution	-Degree of contraceptive distribution -Continuation rates of contraception -Contraception and fertility change
Information and education	-Communication theory	-Different communication channels and behavioral changes -Message analysis	-KAP change -Awareness of population problems -Method awareness -Effectiveness and efficiency of communication channels and messages
Training	-Model development	-Analysis of trainee characteristics -Trainee selection guidelines -Curriculum development -Comparative training method	-Evaluation of effectiveness and efficiency of training program
Organization	-Organizational structure and functions	-Effectiveness and efficiency of the various organizational model	-Evaluation of the impact of structural and functional variables

Table 6. Proposed Direction of Research and Evaluation Activities (cont'd)

Research field	Basic research	Applied research	Evaluation
Social and economic policies	-Social-economic motivation for small families	-Means to increase social and political support -Integration of F.P. and other activities -Relationship between social institutions and F.P. program -Relations between F.P., health and economic status -Community level population policies	-Measuring effectiveness and efficiency of social and political support -Evaluation of the effectiveness and efficiency of integrated programs

Since 1962, a total of 259 projects have been carried out as a part of the research and evaluation activities of the Korean national family planning program. As shown in Table 7, 213 projects have been conducted at universities and other institutes while 46 were carried out by Korean Institute for Family Planning. By major field, 123 projects were concerned with the provision and utilization of contraceptive services, while 81 were focused on demographic or socio-economic studies of the population. There has been a notable lack of research related to IE & C, organizational issues and training. Research has been concentrated on socio-economic support because of interest in overall socio-economic development apart from the family planning program. Past research and evaluation in relation to family planning has concentrated excessively on the provision and use of contraceptive services. New directions are needed if the program is to benefit from this work.

Table 7. Research Activities by Subject Area, 1962~1975

	Basic research		Applied research		Program evaluation		Total	
	KIFP	Other	KIFP	Other	KIFP	Other	KIFP	Other
Provision of services (including abortion)	7	49	8	20	10	29	25	98
IE & C	0	14	0	11	3	0	3	25
Training	0	3	0	10	1	0	1	13
Organization	0	0	2	2	3	6	5	8
Social factors	6	58	6	10	0	1	12	69
Total	13	124	16	53	17	36	46	213

Source: *Report on Korean Population Information Survey.* Korean Institute for Family Planning. 1975.

In order to conduct more appropriate research and evaluation in the future, needs in each field of study must be carefully reviewed.

Such a review should not only eliminate problems of funding inefficiency due to the duplication of research and excessive concentration in selected areas, but should also help to uncover areas which have been neglected in the past.

Training

Training of those involved in family planning activities is very important for the success of the program. For this

Table 8. Training Program Performance, 1971~1975

Personnel	(period)	Number of trainees				
		1971	1972	1973	1974	1975
Field workers	(1 week)	905	872	1,090	1,126	929
Physicians	(1~3 days)	175	43	102	493	368
Administrators	(2~5 days)	47	135	751	1,179	1,512
Others	(1 day)	16	93	1,009	4,675	5,395

Source: Korean Institute for Family Planning. Service Statistics.

reason, training programs have been organized for field workers, physicians, and administrators from the earliest stages of the Korean family planning program. Training is focussed on technical skills for field workers and clinical physicians, and general programmatic knowledge for support personnel. Subjects covered by the training program are IE & C, clinical techniques, population problems, and general administrative procedures. Achievements of the training program during the past five years is shown in Table 8.

In the early stages of the program, the turnover rate of nurses and physicians was over 30 percent annually largely because of overseas employment and low wages. This situation has brought many difficulties to the training program and its goal of maintaining qualified workers. By the 1970s, family planning field workers were comparatively young and had relatively little experience. In spite of one week's intensive training for newly employed workers, they were not adequately skilled to work effectively on IE & C activities and the provision of contraceptive services. Even physicians designated to provide family planning services by the government have not been as active as had been hoped. Moreover, the high rate of turnover of administrators added yet another problem for the training program. The function of central and local supervisory teams which were organized for program supervision was ineffective and supervisory training for the personnel concerned not sufficiently active. Because of these circumstances, both specialized technical training and motivational training for those in the family planning field has not been satisfactory.

In the case of refresher training for field workers, improvement of their skills has not been very successful because of unsatisfactory curricula and lack of training

evaluation. Because of the family planning workers' instability due to their status as temporary staff and their poor working environment, complaints are growing among experienced workers who gradually devote less effort and interest to the program. Designated physicians who have not received training within the past ten years are likely to be out of touch with modern methods and techniques, especially in sterilization. They should be retrained and re-assigned according to their qulifications.

The context of family planning in Korea has changed a great deal in the 1970s. The rapid increase of eligible women has brought about significant changes. Program activities of the health center network have been extended to the village level through Mothers' Clubs, and direct or indirect administrative support from the local office of the Ministry of Home Affairs has been gradually being strengthened. Because of these changes, group education and supervisory functions of field workers are more important than what used to be a primary function of home visiting. Since the family planning program is being integrated with the New Village Movement program, the manpower is more diversified. Instructors' training is urgently required in order to extend family planning training to New Village Movement programs as well as to various other training organizations. Change and expansion of the program have brought rapid development of the family planning field and an increase in the diversity of workers. In manpower training, decisions of priority, specialized training materials, new training methods, careful selection of instructors, and curricula should be developed.

Based on a review and evaluation of the current training program, the following strategies for the training program

during the period of the Fourth Five-Year Plan have been proposed.[24]

(a) Family planning field workers and clinical workers will be utilized as at present but their functions will be adjusted and scientific training given.

(b) Mothers' Club members will be trained more effectively to serve as contraceptive service distributors.

(c) Training will be extended to more private practitioners to encourage their participation in the program.

(d) Instructors' training will be strengthened and extended to include personnel from Ministries and other government training institutions not proviously involved in family planning special emphasis will be put on training instructors involved in the New Village Movement.

(e) Through the training of high-ranking administrators in leadership, supervision, management, and administration for development, more efficient use of the financial and other resources of the program will be encouraged.

(f) A new training model will be developed and continuous evaluation of the program will be made.

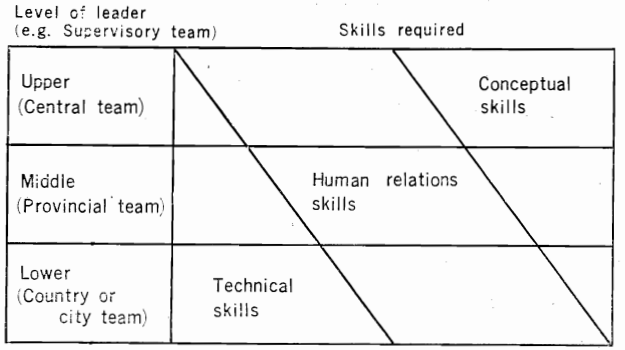
Supervision

Strengthening the supervisory function of the family planning program is required for the maximization of program effectiveness. To make the supervisory function effective, supervisory teams at each level should be adequately staffed and have skills necessary for their activities.

As shown in Figure 5, human relations skills are required

24) Ministry of Health and Social Affairs. The Fourth Five-Year Family Planning Program Budget. Mimeo. 1976.

Figure 5. Supervisory System and Skills Requried at Each Level of Leader



equally at all levels. Conceptual skills are more important at the upper level of the program, while technical skills are needed more at the middle and lower levels. The central supervisory team, of course, needs a certain degree of technical skill to function effectively.

In the Korean program, supervisory teams at each level are not well coordinated. Provincial, county and city supervisory teams are not able to function effectively because they lack knowledge and skill related to program evaluation. Above all, managerial training for each level's supervisory staff is urgently required.

Leadership

The control function provided by high quality leadership is essential for successful family planning program performance. For overall program policy decisions and support for program implementation, strong and continuous leadership is necessary. In the Korean family planning program executive leadership within the Ministry of Health and

Social Affairs has been strong, although interest in the program among other senior government policy makers has been intermittent.

At the central level, coordination and cooperation among ministries is weak. Moreover, utilization and support of related social agencies such as the press and religious organizations are also deficient. In solving these and other leadership problems in the Korean program considerable help is expected from the Population Policy Coordination Committee, organized in 1976. The committee is chaired by the Deputy Prime Minister and will coordinate population activities at the central level. In addition, coordination systems must be established at the provincial level for efficient program performance in the field. Strong leadership in family planning programs is often found in national programs of developing countries. There are many countries in which family planning and population activities are directed from an office under the president or prime minister. Korea too must move in this direction. The newly formed Population Policy Deliberation Committee is an important development in the report.

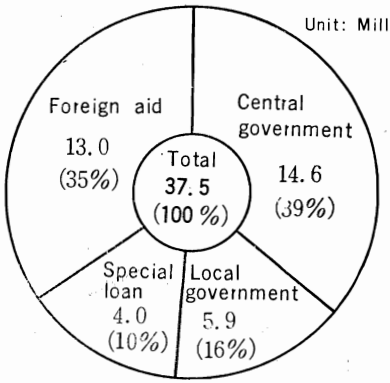
Finance

Finance as a supporting function is also very important since the success of any program depends heavily on effective budget management and allocation. Typically, it is felt by program personnel that existing funds are not sufficient to meet program goals. A persistent problem in all programs is how to allocate limited funds to different functional fields in order to achieve the goals of the program. The priorities for budget allocation should be based systematic and rational program diagnosis. Unfortunately pro-

gram budgeting in Korea has taken place without adequate or systematic budget evaluation. Because of this, the Korean Institue for Family Planning is currently designing a study of management and budget aspects of the program in order to determine the most effective and efficient directions and priorities for projects and budget allocation. In this paper only general aspects of the program budget and some of the problems related to them will be discussed.

As shown in Figure 6, the total budget of the family

Figure 6. Budgetary Inputs (1962-1975)



Source: Korean Institute for Family Planning, 1975 Annual Report.

planning program from 1962 to 1975 was 18.2 billion won ($37.5 million) of which 39 percent was from the central government, 16 percent from local governments, 10 percent from special loan funds 35 percent from foreign aid. The proportion of foreign assistance in the Korean program has been relatively high over the years, but is declining rapidly and is likely to terminate altogether by 1978, thus proportionately increasing the government share of the total budget.

Approximately 7.3 million Korean couples received family

planning services from the government through 1975. The per capita cost for acceptors has been calculated at roughly five dollars. Since the total number of births averted by the program is estimated at 3.02 million, the unit cost per birth averted by the program equals $12.40. Such costs are expected to increase because of inflation and the rising cost of program supplies and personnel; the budget input should be increased proportionately. Investment in the family planning program should be increased. The benefit of the family planning program during the period 1962~1973 has been estimated to be 71 times the total government investment.[25] Such benefits would be rapidly increased with expansion of the program. Considering its influence on national economic and social development, budget priority should be given to the family planning program.

A more efficient allocation and use of the budget within the program would also make it possible to contain cost increase for contraception and birth prevention. To date the handling government family planning program budget has been marked by a lack of flexibility. For example, in budget appropriations for contraceptive services it is difficult to transfer funds from one method to another. Thus, when the allocated target for a certain method has been achieved no attempt is made to motivate additional acceptors although unused funds originally earmarked for other methods may be available. In this respect, the adoption of a more flexible system of budgeting and accounting is necessary. One approach may be to adopt a block grant system to the program to cope with problems caused when an allocated target is achieved earlier than planned, or when

25) Han, K. C., *Cost Benefit Analysis on Korean Family Planning Program.* Korean Institute for Family Planning. 1973. pp. 111~113.

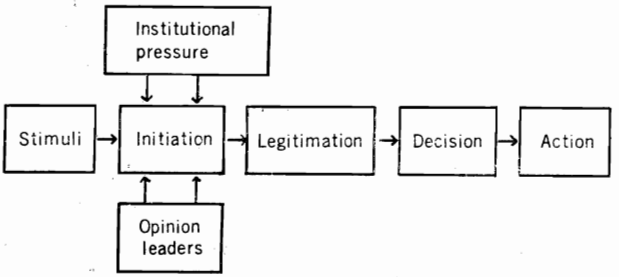
unexpected and urgent projects require immediate budget allocation.

In practice family planning acceptor target in past years have been set more according to available funds than to program requirements. Although there are many difficulties in budgeting due to the limitation of government funds, special consideration should be given to the family planning program because of the growing significance of population problems.

Social Support Program

Even the best system for providing contraceptive services and information, education and communication would fail to substantially change fertility if normative change toward smaller family size ideals did not take place. Although IE & C services have been steadily provided in Korea in an effort to reduce the strong traditional preference for sons and large families, we are still some distance from fully modernizing these attitudes.

Figure 7. Behavioral Change Process



Source: Rogers, E.M., *Communication of Innovation.* New York, Free Press, 1971.

As seen in Figure 7, normative change toward small family size can come about through outside stimulation, legitimation of the norm by important reference groups, or individual decision making. Legitimation within the group often results from socio-institutional pressure, led by opinion leaders. This, for example, is the case of the New Village Movement in Korea. The reason the New Village Movement has been so successful is that the program has been legitimized within the community because of its identity with Korea's political and community leaders. Similarly, legitimation of the small family norm must exist within the community or reference group or the family planning program will not be successful. In designing social support programs to encourage small family norms, both institutional and normative support should be considered simultaneously.

INSTITUTIONAL SUPPORT

Since a variety of factors must be considered in implementing institutional support programs in support of family planning, the cooperation of experts in related fields is necessary. Actual institutional supports which can be considered in the Korean context include the following:

1) Limitation of tax exemptions to two children. A recent revision of the income tax law will introduce this measure in 1977.
2) Priority to small families in public housing.
3) Obstetrical service charges which increase with parity
4) Revision of all laws related to small family size norms. For the revision of these laws, continual and intensive study should be made as a number of difficulties are anticipated in this area.

5) Equal opportunity for women in employment, wages, and promotion, to reduce son preference.
6) Lessening the reliance on one's children in old age through the development of a social security system.

Applicability of these institutional support policies should be studied and adopted as soon as practical.

NORMATIVE SUPPORT

For institutional support to be most effective, normative support should be provided concurrently. Small family size norms can be formed through various educational programs. Normative support may be attained through academic curricula and adult education. While the former is directed toward the next generation, adult education is able to concentrate on the current target population. As such, the latter is an effective means of reaching the opinion leaders who have leading roles in normative change in the community. Education of opinion leaders can be carried out effectively if the various educational programs offered by the government are integrated with population education programs. For example, in the case of agricultural education programs, population problems, may be introduced in relation to agricultural mechanization. For these programs, the development of specialized teaching materials for different groups and the training of instructors should take place prior to program implementation.

CONCLUSION

During the last decade and a half, the Korean family planning program has been most successful. The total fertility declined from 6.3 in 1962 to 3.5 in 1976. Such fertility change has resulted not only from the activities of

the family planning program but also from a number of related factors such as the increase in induced abortion, later age at marriage and overall socio-economic imporvement. Although it is difficult to measure the respective contributions of each of these factors to fertility change, there is no doubt that they have combined to yield effective results.

Looking ahead, however, contributions from are at marriage and induced abortion will doubtless decline. Furthermore, beginning in the late 1970s the post Korean War baby boom will be felt as a wave of new parents and will create sharp upward pressure on the crude birth rate. An equally serious problem is that ideal family size expressed by eligible women in Korea is still 3.1 children, of whom two are sons. Under these circumstances, further reductions of the natural increase rate will be impossible without an active family planning program that can provide the highest quality services to all women. Also needed are changes in traditional norms, especially those of son preference and large family size. None of these crucial changes will come about without a constant effort at program improvement and an attempt by all those concerned about the impact of population on the development of Korea to provide support for the family planning program, as well as for those institutional and normative changes needed to reduce excessive population growth and its undesirable side-effects.

Lee, Jae Chang*

CHAPTER 2

New Village Movement and Family Planning Program

The "New Village Movement" advocated by President Park, Chung Hee on April 22, 1970 is national drive aimed at improving individual well-being as well as building a welfare state. The major objectives of the New Village Movement are summarized as follows:

—*To build economic wealth and promote spiritually sound, and dignified cultural living.*

—*To enhance individual living and further promote well-being of neighbors and all countrymen, and*

—*To ensure the well-being of the forthcoming generations.*

In the initial stage of the New Village Movement, the Movement was mainly undertaken by farmers to improve rural environments during the off-seasons. But the genuine

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concept of the Movement lies in spirits for deligence, self-help and cooperation. And the Movement itself is a consecutive process of self-reform leading toward the welfare of the individual community and the country by exercising careful review of individual thought and action and through self-orientation. Therefore, it is thought that the New Village Movement is not necessarily limited to the participating agents of time and space. The major components of the Movement are classified into the following three categories.

Spiritual development:

—Deligence : Faithfulness, austerity, scientific and reasonable thought, and efficiency

—Self-help : Self-sustaining, courage, pioneer, and creativity

—Cooperation : Solidarity, order, neighborhood, love of native place, patriotism

Economic development:

—Creation of productive foundation

—Increase of production and income

Social development:

—Development of social welfare facilities

—Establishment of ethics and disciplines

—Development of healthy environment

—Development of dignified cultural activities

Accordingly, the New Village Movement is composed of a comprehensive forms and methods in the aspect of social development. Detailed programs of the New Village Movement are as follows:

Spiritual development:

—A nation-wide education program on the New Village Movement

—Village Credit Union, saving campaign

—Family planning
—Family rituals
—Observance of laws and order
—Development and practice of traditional social ethics (patriotism, love of native place, rituals, cooperation, assistance to neighborhood, preservation of cultural relics)

Development of welfare and environment:

—Improvement of roof and houses
—Farming roads, village roads, sewage, bridge
—Village hall, public bath house, children's park
—Soil control (roads, river arrangement)
—Simplified water supply facilities
—Electrification, Telephone

Increase of income:

—Scientific farming for food production and cooperative efforts
—Improvement of farming structure(cash crops)
—Cottage industry(handcrafts, New Village Movement Workshop)
—Wage-earning program
—Mulberry and forestation
—Operation of cooperatives
—Basic facilities for farm production(reservoir, farmland and warehouse)
—Fishery farm

METHOD OF IMPLEMENTING THE NEW VILLAGE MOVEMENT

The New Village Movement is being implemented by voluntary participation of residents and their self-help eff-

orts.

—Election of New Village Movement leaders

—Selection of programs under the New Village Movement

—Cooperative works

—Management of community facilities

The New Village Movement is being implemented through voluntary efforts generated from new village spirit emphasizing action rather than theory.

—Undertaking easy and immediate works : self-discovery

—Continuation of program : discovery of feasibility

—Analysis of program achievements : confidence and experience of new village spirit

Since the basic unit of the New Village Movement is individual village, the village in this context imply not only the concept of community but also refers to psychological community oriented toward common consciousness and profits.

—Rural community : village

—Urban community : family, job site, village (Tong /Ban), plant, school, agency

The New Village Movement is being implemented under the leadership of the new village leaders.

—Election of leaders having strict new village spirit leadership

—Integration of opinions of residents

—Guidance of New Village Movement program and cooperation with government authorities

The following factors should be considered in selecting New Village Movement programs.

—Consensus among the residents

—Desirability and concern of residents
—Relationship with increase of income
—Capability of residents and community characteristics
—Equitability of profits

Promotion of a wide participation of all components in the New Village Movement.

—Operation of Ri/Dong Development Committee
—Promotion of participation of formal and informal organizations
—Promotion of functional New Village Movement networks

The Government of the Republic of Korea will motivate the people to voluntarily participate in the New Village Movement on a nation-wide basis. The Government will simultaneously provide pre-post program guidance with a minimum level of support. In providing assistances, New Village Movements programs are to be evaluated in three categories(basic village, self-help village, and self-sustaining village).

A priority of assistance is provided to the selected "self-sustaining" village.

—Materials for new village(cement, steel, etc.)
—Monetary loan
—Technical guidance
—Evaluation and adjustment of program plan
—Compose of system for guidance and assistance(central and local; refer to Figure 1)

Education on the New Village Movement will be continued to maintain the continuity of the New Village Movement(spiritual and technical education).

—New Village Movement leaders : New Village Movement Leaders' Training Institute(central and local)

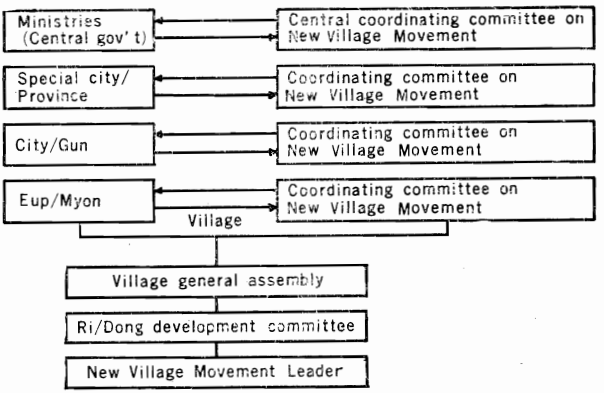
—Government officials and social leaders : Government Officials Training Institutes and the New Village Movement Leaders' Training Institute.

—All people in employment and communities : all educational institutes, local education including farming education and general education for citizen.

ACHIEVEMENTS OF THE NEW VILLAGE MOVEMENT

A summary of the achievements of the New Village Movement in the past five years reveals that we have learned the potential way of improving our living. If we quantify the achievements, the Government invested 225

Figure 1. Structure fer New Village Movement



billion won which turned out 570.6 billion won in terms of achievements, 2.5 times of the total inputs. A comparison of the developmental indices in rural areas for 1971 and 1975 is as follows:

Table 1. Rural Developmental Indices

Item	Unit	1971	1975
GNP per capita	US $	252	531
Agricultural growth	%	1.7	6.2
Farming population	%	46	37
Annual income per farming household (compared with the income of urban worker)	US $ (%)	813 (71)	1,818 (102)
Agricultural expenses against GNP	%	8.4	18.6
Rice production per hectare	M/T	3.3	3.9
Agricultural commodity export	US $ 1 mil.	178	638
Arable land per farming household	ha	0.92	0.94

Source: Fourth-Five Year Economic Development Plan(Agricultural Sector).

Following is a further study of the achievements in the aspects of spiritual development, production and income, and welfare and environments.

Spiritual development:

1) A great reform has been effected in cognitive structure of the villagers. The cognitive structure has been changed to motivate the villagers to enjoy potentiality and confidence in "we will succeed if we try", and furthermore generated willingness and belief in "we can improve our living" by eliminating stagnation and idleness.
2) Villagers experienced the principle of self-disciplinary cooperative efforts. In the process of implementing cooperative New Village Movement programs, the partici-

pants renewed the awareness of the partnership, "we", and the principle of cooperation(1+1=2+a).

3) Established a nationally unified system. The New Village Movement in rural areas expanded over the urban communities as well as toward the overseas development activities. These achievements contributed greatly to the nation's unity.

4) The voluntary participation of women has reformed living and order. With the inception of the New Village Movement, women, particularly women in rural areas, served in reforming unreasonable and unproductive livings and social order.

As a new movement, various programs are now being implemented, including promotion of savings, improvement in clothes, foods, and living, family planning, conservation of materials, simplification of family rituals and elimination of superstition.

Production and income:

1) A foundation for production and income has been arranged. Development of village and farming roads and the construction of bridges directly linked the villages to the high ways and local roads, which has contributed to the mechanization of farming and to the flexible circulation of agricultural commodities.

2) And the development of irrigation systems, farmland development, paddy-land rearrangements, and rural electrification program provided an epoch-making occasion for an increase of income among the rural communities.

3) The cooperative efforts and scientific farming introduced a new way of production. The cooperative efforts of residents increased economic gains while developing a new source of income (rice-planting, joint insecticide oper-

ation, vinyl house, cattle breeding, etc.).

In addition, a newly developed technology in farming increased acreage-production.

4) Idle labor force and materials become productive factor. During the non-farming seasons, rural population are busily engaged in beautification activities, New Village Movement works, cash-crop raising, wage-earning projects, and various plants.

All unattended stones, sands, gravel, hills and river-basins are turned into a source of income.

Improvement of environment:

1) Eliminated the prolonged poverty, stagnation and idleness in rural communities.
2) Re-arranged the basic living sphere around the villages. The New Village Movement program included housing, improvement of wall, reshaping of premises and village roads, re-arrangement of sewage and rivers, forestation, farmland re-arrangements, etc.
3) The New Village Movement provided various cultural facilities needed in modern living. A rapid change took place in farming and fishery communities. Communication system, simplified piped water-supply, and rural transportation facilities have been expanded on a village basis. In addition, village hall, public bath house, consumer market, and storage have been increased to a great extent.

FAMILY PLANNING PROGRAM

1) The National Family Planning Program aims at increasing the distribution rate of national income by limiting the rapid growth of population, and further aims at

enhancing the national economy and social welfare. The growth of population in the world today poses a serious global problem in relation with the issues of resources and environment of the earth. It is estimated that the population of the world will reach 8 billion in early 21st century at an increase rate of 2 percent from the current 4 billion. According to the 1975 national census, Korea's population was 35.4 million, with a high birth rate of 24 per 1,000. However, it is estimated that the population of Korea will continue a rapid growth as the death rate is declining from 7 per 1,000. Although the average number of children declined to 3.5 in 1975 from 6 in 1960, a 2.5 reduction during the 15-year period, it is generally agreed that there will be many difficulties in reducing the average number of children to 2. Even if we reduce and maintain 2 children in the future, the total population will increase to 48 million~51 million in the year of 2000. The Fourth Five-Year Economic Development Plan(1977~1981) is designed to reach 38.83 million in 1981. However, with the anticipation of a rapid growth of reproductive female population, declining age of first marriage, stagnant induced abortion, etc, it is assumed that the birth rate will continue to increase. Therefore, it is estimated that the population growth rate will reach 1.6 percent even though we implement the National Family Planning Program and emigration services during the plan period.

In order to achieve the goals of the national economic development and social welfare, an appropriate level of population must be maintained, which calls for the implementation of family planning program.

2) We have been implementing the National Family Plann-

Table 2. Target of Population Growth

Year	Population	CBR	CDR	NIR	Emigration	Population growth rate
1977	36,450	23.50	6.24	17.26	1.58	15.68
1978	37,029	23.49	6.12	17.36	1.71	15.66
1979	37,618	23.58	6.01	17.58	1.84	15.74
1980	38,219	23.73	5.90	17.83	2.01	15.82
1981	38,834	23.88	5.80	18.08	2.15	15.93

Source: National Family Planning Program and Direction. KIFP.

ing Program since 1962 and integrate into the New Village Movement beginning 1972. It is estimated that as a result of the acceptance and practice of family planning by 7.39 million during the period of 14 years from 1962~1975 a total of 3.02 million births have been averted (source: National Family Planning Program and Direction, KIFP). The future measures of the National Family Planning Program, as integrated into the New Village Movement, are as follows (Comprehensive measures of 1976 New Village Movement, Central Coordinating Committee on New Village Movement):

—Promoting voluntary participation of people by strengthening IE & C activities.

—Increased efforts in urban areas, as well as rural communities.

—Expansion of the program coverage through the Mothers' Clubs.

—Strengthening the sterilization program.

—Promotion of voluntary participation of private sector by expanding hospital-based family planning program.

The achievements of the National Family Planning Program during 1972~1975 are summarized in the Table 3.

Table 3. Achievements of the National Family Planning Program

Category	1972	1973	1974
FP fieldworkers	2,393 Pers.	2,393 Pers.	2,591 Pers.
Operation of mobile clinics	22 Teams	21 Teams	11 Teams
Contraceptive supply	400,000 Pers.	442,000 Pers.	424,000 Pers.
Permanent sterilization	20,000 〃	22,000 〃	34,000 〃
Long-term contraceptive	300,000 〃	300,000 〃	383,000 〃
Menstrual Regulation	—	—	—

Category	1975	Total
FP fieldworkers	2,591 Pers.	—
Operation of mobile clinics	11 Teams	—
Contraceptive supply	450,000 Pers.	1,716,000 Pers.
Permanent sterilization	35,000 〃	111,000 〃
Long-term contraceptive	350,000 〃	1,333,000 〃
Menstrual Regulation	4,000 〃	4,000 〃

Source: The New Village Movement in 1975. Ministry of Home Affairs.

Regarding the channel of contraceptive supply, the contraceptive services are delivered/mainly through the Health networks down to about 1,500 designated clinics and 2,591 family planning fieldworkers. In addition, more than 750,000 members of the Mothers' Clubs are engaged in the program. And there are branches of the Planned Parenthood Faderation of Korea (PPFK) in each Special City and Province. Family planning services are also delivered at hospitals, urban clinics, industrial plants, and military hospitals. So far the Ministry of Health and Social Affairs has been administered the National Family Planning Program, but the Population Policy Deliberation Committee

was established in 1976 to facilitate ministrial supports in dealing with the growing population problems.

In the aspect of social and institutional supports, the Income Tax Law has been revised to accord tax exemption to only 2 children. And the sterilization service is provided free of charge to the acceptors of the permanent contraception. Free contraceptive supplies are also freely given to the acceptors.

Necessary training is provided to the family planning fieldworkers at the Korean Institute for Family Planning (KIFP). The trainees include the family planning fieldworkers, members of the Mothers' Clubs, medical doctors and clinical personnel. Training is also provided to the administrative personnel supporting the National Family Planning Program and to other leaders. The achievements of the training program are as follows Figure 2:

A total of 18.2 billion won has been invested into the National Family Planning Program as follows:

Figure 2. Achievements of Training Program(1971~1975)

Unit : Person

Trainees (duration)	Achievements				
	1971	1972	1973	1974	1975
FP fieldworkers(1week)	950	872	1,000	1,126	929
Doctors(1~3 days)	175	43	102	493	368
Administrators(2~5 days)	47	135	751	1,179	1,512
Others(1 day)	16	93	1,009	4,675	5,395

*Adminsirator: Chief of Internal Affairs Section, County: Chiefs of Eup and Myon.

Others : College volunteers, health and medical students, senior university students and members fo the related organizations.

Source : The National Family Planning Program and Direction. Korean Institute for Family Planning.

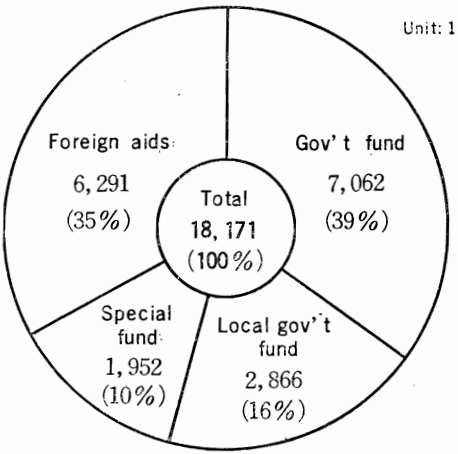
The findings of an analysis of the National Family Planning Program suggested the following recommendations as effective implementation of the program.

—Expansion of the channel of contraceptive supply.

—Strengthening and expansion of IE & C actvities.

—Strengthening the guidance and supervisory activities.

Figure 3. Budgetary Inputs (1962-1975)



Note: 1. Program cost per person: 2,470 Won
2. Unit cost per 1 birth averted: 6,000 Won
Source: The National Family Planning program and direction KIFP.

Table 4. Budgetary Inputs by Area

Category	Gov't fund	Foreign aids	Total
Contraceptive supplies	76	30	60
IE & C	2	28	11
Research and evaluation	2	8	4
Training	2	25	10
Program management	18	9	15
Total	100%	100%	100%

Source: The National Family Planning Program and Direction. Korean Institute for Family Planning.

—Establishing equitability for social and policy supports.

—Expansion and strengthening training program for fieldworkers.

—Increase of financial inputs.

The family planning program should be developed into a comprehensive community development program as a step forward from a simple clinical operation. Because it is thought that the family planning program should be implemented through a multi-disciplinary approaches for a success.

RELATIONSHIP BETWEEN THE NEW VILLAGE MOVEMENT AND THE FAMILY PLANNING PROGRAM

A study of the relationship will contribute to the development of ways and means of integrating family planning services and the New Village Movement. Firstly, family planning service can be considered as a means of achieving the goals of the New Village Movement, in view of the fact that an optimum population will enhance the standards of living and environments. Secondly, the implementation of the family planning service can be closely related to the method of the New Village Movement, whereas the acceptance of family planning requires a certain motivation to people to change their cognitive structure and to voluntarily practice family planning, and also requires administrative guidance and supports. Thirdly, the family planning program can utilize the existing basic unit of the New Village Movement. The unit can consist of village in rural areas, and households and areas (Tong and Ban) in urban

areas, employment, plant, school, etc. Fourthly, the family planning program may well be affected by the achieved foundation in the New Village Movement. Namely, the New Village Movement first provided a transition from the view of destiny towards reasonable and scientific thought, and further promoted the idea of partnership towards cooperative society. Second, our rural society, while transforming from a stagnant society to a dynamic society, is becoming readily prepared to accept a new external motivation. Third, especially, in urban communities, the growing opportunity for employment and transitory nuclear family from a large family played a role in limiting a high parity which impede child-rearing. Fourth, the rising standard of living, increase of income, and an expanded medical services will naturally lead towards to a low fertility and low mortality rates. Accordingly, it is thought that villages with well-disciplined in the New Village Movement and actively engaged in high income program will likely to succeed in the family planning area, otherwise they are doomed to experience a process of hardships. As discussed above, there is no doubt that the New Village Movement is closely related to the family planning program in terms of their purposes and means. Therefore, there is a need for development of ways and means to integrate the family planning program and the village movement in order to ensure their efficiency.

IMMEDIATE TASKS IN IMPLEMENTING THE NEW VILLAGE MOVEMENT AND THE FAMILY PLANNING PROGRAM

It is thought that although the Family Planning Program

has been carried out since 1972 as a part of spiritual development aspect of the New Village Movement, improvement should be made in the aspects of institutions and management in order to link together the organizational structure and implementation. Firstly, it should be pointed out that the implementing organization in the Family Planning Program is independently operated from the structure of the New Village Movement. Namely, in City, County, Eup and Myon, there has been a tendency to think that the Family Planning Program can only be carried out by the Health Centers and Family Planning Field Workers.

This tendency has caused the omission of the subject as part of the agenda for the city, county, Eup and Myon Coordinating Committee on the New Village Movement. In villages, Ri and Dong development committees or the New Village Movement leaders were often alienated from the family planning program, since it was thought that the family planning services should be carried out by the Mothers' Clubs. Secondly, the National Family Planning Program, since it was thought that the family planning services should be carried out by the Mothers' Clubs. Secondly, the National Family Planning Program is being carried out without full utilization of the ways of the New Village Movement. The following are the examples:

- *In villages and employment, the implementing units are not matched for both the New Village Movement and the National Family Planning Program.*
- *Villages are not provided with well-planned and proper program target based on survey.*
- *There are lack of conditions and motivation for villages to voluntarily implement family planning. Namely, there is a need for establishing a reward*

system for outstanding family with successful family planning, or villages with outstanding records, or detection and introduction of cases leading a happy home without a son through a successful family planning.

- ▶ *There is a lack of family planning field workers compared with New Village Movement leaders.*
- ▶ *Since there is no curriculum developed to be included in the education the New Village Movement, the training and education is limited to those being trained at the Korean Institute for Family Planning.*
- ▶ *The exclusion of the Family Planning Program from the annual year-end evaluation of the New Village Movement eventually reduced the concern among the mayors, county chiefs, and Eup and Myon chiefs over the family planning. Also it lacks proper evaluation of the program achievements.*

EFFECTIVE METHOD OF IMPLEMENTING THE FAMILY PLANNING PROGRAM THROUGH THE NEW VILLAGE MOVEMENT

A study of the immediate problems suggests the following recommendations:

1. The structure of the New Village Movement should be utilized at a maximum level in order to expand and strengthen the National Family Planning Program. In the central level, the New Village Movement Coordinating Committee, composed of bureau directors of the ministries concerned, and the New Village Movement Coordinating Committee, composed of the Vice Ministers, should be

briefed on the policies of the National Family Planning Program to obtain cooperations from the respective Ministries. The same procedures should be carried out in special city, province, city, county, Eup and Myon to obtain cooperation from various agencies. In urban areas, a report on the National Family Planning Program should be made to the Private Coordinating Committee on the New Village Movement, composed of the representatives of various organization, in order to obtain necessary assistances and supports. IE & C materials on the family planning should be provided to the Mass-Media Coordinating Committee on the New Village Movement, composed of the representatives of the broadcasting systems to enhance the effectiveness of the IE & C activities. The Korean Institute for Family Planning should request the Ministry of Home Affairs to take necessary action to include the family planning in the agenda of the Ban meeting to be held throughout the country on 25th of each month. IE & C materials should be produced by the Korean Institute for Family Planning for this purpose. In order to make the New Village Movement leaders as a local leaders of the National Family Planning Program, all the New Village Movement leaders in the country can be appointed family planning leaders. In the villages, the Family Planning Program should be adopted in the agenda of the Mothers' Clubs, Ri/Dong Development Committees, 4-H Clubs, Village Credit Union, etc.

2. In accordance with the procedures of establishing the target of the New Village Movement, family planning target population should be surveyed to set annual target for each basic unit.

--Basic unit of the New Village Movement

—Family planning methods

—Village and employment level planning

3. The family planning should be designated as a compulsory subject at all levels of education on the New Village Movement in order to strengthen the family planning education and IE & C activities.

—New Village Movement Leaders' Training Institute

—All training institutes under the Ministries in central level

—Farming education in winter and New Village Movement class

—All citizen's orientation courses (citizen's college, women's class, etc.)

—Mass-media on the New Village Movement

—All educational institutes in Special City and Provinces

—All state-operated enterprises and all public organizations and research institutes

—Ban meeting

—Circuit motion picture service on the New Village Movement

The Korean Institute for Family Planning should provide teaching materials and training for lecturers for the above purposes.

4. The evaluation of the National Family Planning should be conducted at the time of conducting the annual evaluation of the New Village Movement to increase the functions of the guidance and supervision.

—Inclusion of the family planning in the evaluation of the New Village Movement.

—Awards(villages or households)

5. The National Family Planning Program should be deve-

loped as a New Village Movement by medical and health personnel (doctors, nurses and pharmacists, etc.)

—Education and consultation

—Free-of-charge or actual cost

6. The family planning program should be carried out as a New Village Movement various employments and plants.

—Education on the New Village Movement at employments

—Privileges at the time of clinical operation(paid leave and other privileges)

For example, Sam Yang Tire Company, a pilot New Village Movement plant, Kwangsan, Kwangjoo Gun, Chullanamdo, succeeded in achieving the family planning practice rate to 87 *Percent by undertaking the family planning as a movement under the New Village Movement. The following privileges were provided to the acceptors of the family planning*

a. A priority is given to individual having less than 2 *children when applying for employment.*

b. Dependent allowance is provided to only 2 *children.*

c. A priority is given to acceptor of sterilization in plant housing issue.

d. Advance payment of pension fund to the acceptor of sterilization for housing.

e. A priority is given to awards.

f. Provision of delivery care to first delivery of women.

g. Employed a family planning staff in the plant.

h. Regular family planning course for newly employed worker and the newly married couples.

7. In addition the implementation of the family planning

through the Mothers' Clubs, the family planning program should be carried out as a compulsory activity at all villages and employments, as well as in all New Village Movement structures.

—Ri/Dong Development Committee
—Women's Saving Association
—4-H Clubs
—Women's Association
—Village Credit Unions

8. All outstanding villages and households in the Family Planning should be cited at the levels of city and county, and exemplary villages should be analyzed and evaluated to be expanded into other villages.

G.D. Ness Ph.D.*

CHAPTER 3

Family Planning Program Administration from Integration Perspective

This thesis is drawn from a recorded special lecture given during "The training for family planning administrators" held in Korea from November 22th to November 26th in 1976.

Accordingly, we presume there are some parts which don't fully express the lecturer's thoughts and are not suitable for a thesis as it is just a translation from the lecture.

We seek an understanding with readers as well as the lecturer if there are such parts.

I have been studying problems of economic development in Asia for about the last 20 years and I think it will be useful if first of all I try to say something to you about what Korea looks like to an outsider like myself in terms of what Korea is doing in the way of economic develop-

* Professor of Sociology, University of Michigan.

ment and how it compares with other Asian countries.

The first point I'd like to make is this. For about the past 30 years, all countries in Asia have been making very large efforts at economic development; efforts for industrialization and agricultural development, efforts to raise the income of all people in rural areas as well as urban areas, efforts to increase public services like education, health and welfare. In all those areas, when one looks at Asia from the outside, one sees that Korea, your country, has been a real leader in the process of economic development. You have done marvelous things in the past two or three decades in increasing industrial development and agricultural development, in increasing income for all people, and in raising the standard of living for all the people, so people in the rural areas as well as those in the urban areas enjoy a much better standard of living today than they did 20 or 30 years ago.

The second point I'd like to make is that, again throughout Asia since about 1960, for about the last 15 years, most countries have been much concerned with the rapid rate of population growth. And almost all the countries of Asia have taken on major programs, which we call family planning programs, in an attempt to reduce fertility and to reduce the rapid rate of population growth. Here again, Korea has been one of the leaders; not only in Asia but in all the world. You have built a family planning program, a regular program for the distribution of modern contraceptive technology, including the loop, the pill, and sterilization as well as conventional contraceptives that has turned out to be really one of the best programs in the world. It has provided more services, reached more people and had a larger impact in reducing fertility that is the case of almost

any other country in the world; and you should be proud of the efforts that you have made in that regard.

The third point is, over the just last few years many countries in Asia have become much concerned with integrating development programs; with producing what are called fully integrated rural or modern developmemt programs; and also with including family planning in these larger integrated programs. There is a new committee on population that met this last summer at ESCAP in Bangkok and one of its recommendations was that there should be massive attention given to integrated rural development programs that include family planning. Now here again, while the rest of Asian countries begin to think about those things, Korea has already taken action. Again Korea emerges as a leader in attempts - very serious attempts - to integrate a wide variety of development programs and to include family planning in that integration.

In your Saemaul (New Village) program you have made, it seems to me, a very significant attempt to link together a large number of different agencies; to make an integrated development program. The aims of increasing income, of producing a better natural and physical environment, together with the spiritual uplift, are precisely those aims that other countries are looking to and beginning to wonder now how they themselves can achieve the same aims. And I think Korea is beginning to point the way. Most countries, as I think you have found in the recent past, recognize that any development program cannot be successful if it does not pay attention to population as well. If we increase income but still have high fertility; then we will simply eat up most of our new income. If we produce more schools, more class rooms and more education, but still have more

children, then there will not be more education to go around. As we produce more health services, but don't reduce fertility, then we will continue to have very heavy health burdens, particularly on our women and our children. And if we try to raise the status of women throughout the world, which most of the world is concerned with now, we cannot do so without attention to fertility and fertility control programs. If can be seen then, that any of the development programs we wish to promote will require attention to family planning. At the same time we have found in family planning programs in other countries that if they are really to succeed, if they are to make a large impact on society, then they must be put in with other programs as well. Family planning requires other development programs and other development programs require family planning in order to be successful.

The fourth point I would like to make is that your Korean family planning program is somewhat unique and it is much noted for the attention and research it has done on what we call organizational problems. Now it seems to me it is very important for any group of government leaders who are making a development program of any sort, whether it is family planning or agriculture development, to pay attention to the organizations that they themselves control. If you pay attention to the organization that you are in, then you are concerned with what you can do to provide better service. Now the alternative to this - an alternative that we often find in government programs - is reliance on what we call "blaming the victim". Schoolteachers would prefer to blame the children for being stupid rather than ask what they can do to be better teachers. Agricultural development officers may sometimes prefer to blame the

farmers for being stupid rather than ask what they can do to provide better services to the farmers. Family planning officers sometimes blame the women for being to stupid to accept the new devices rather than asking what they can do to provide better services to those women and those families. When you pay attention to the organization problems, when you do research on the organization problems and ask yourself what the organization is like; then you are asking yourself what you can do to make a better program, rather than what the clients can do to move things along. Now it seems to me that Korea has paid more attention to organizational problems than have most of other countries. In fact, I think this is one of the very first training programs in the region where administrators in various parts of civil administration and in various kinds of organizations are provided family planning training. This is rather a unique thing. I would like to just mention two studies, two kinds of research, that your own people have done here that had a great deal to tell the rest of the world about the importance of organizational problems and organizational issues. The first was done by Dr. Han Dae Woo on leadership in family planning programs. He discovered from a very careful, very systematic, very scientific piece of research, that when administrators and leaders like yourselves-county chiefs, health center directors, provincial bureau chiefs and so on - are (1) willing to help their staff with administrative problems and technical problems such as helping them work out the budget, helping them solve various technical problems about how you explain this side effect or that side effect to people, (2) when they are willing to help their staff make an effective group with others and work effectively in a group, and

(3) when the leaders are willing to help their staff get resources from other parts of the administration such as acquiring more money transportation and making the paperwork run smoothly for them; when leaders are willing to do these sorts of things, then they get more work out of their staff. So leadership Dr. Han found, was an extremely important element in increasing the efficiency and impact of the program. The second very important study was done by Dr. Kim Kwang Woong on the administration of family planning programs here in Korea. We did the same kind of study in Malaysia, Singapore, Indonesia and the Philippines as well, but the program research worked best here in Korea. And his research showed that when family planning workers work together with people in other agencies, when they have lots of contact with people in other agencies, when they give time to other programs and when they feel they have support from other programs; then the family planning program works much more effectively. So that when you have a program where you can help your staff make contact with people in other agencies and help other agencies make contact with people in family planning, when you can build work groups in which people in from different agencies are helping one another and feel that all together they have a responsibility for making the county program work or the township program work; then you get a much better program; one that provides far better family planning services for all.

For the final point perhaps we could get down to some more specific suggestions, models or rules, about how one can make an integrated program of any sort work and work fairly effectively. For this I'd like to drawn on an experience that I had watching a very effective rural deve-

lopment program; the Malaysian rural development program which was for its type of program and for that time(1959~1964), one of the most successful government development programs that we have seen. And it developed some fairly simple, but very useful, organizational rules that might be worth hearing about and possibly copying.

First of all, the program decentralized a great deal and got people at all levels to work together. Malaysia is divided into states which are further divided into districts. The comparable units in Korea would be the provinces and the counties. And at the lower level, in Korea's case at the county level, there would be a committee that would include all of the technical officers from that county,or district, who would sit down together at a meeting once a week. Every week they met together for two, sometimes three and four hours, and they did a number of things at those meetings. One of the things they did was to make their own targets and make their own plans. So down at the lowest levels, where the real operation of any program happens; people were sitting down and collectively deciding what they should do and collectively they were making their own targets. Now those targets were ambitious targets, but they were also very realistic targets because they were made by people at the lower levels who knew what they were able to do as well as what they wanted to do. Second, in making these targets and in meeting every week, they could come together and give each other a lot of information about how the program was going. Every one could report each week on what they were doing to achieve their particular target. Perhaps more important they could report to one another on what problems they were facing, where they ran into obstacles, where they could not move

something, where they ran into resistence from local people or part of the government operation itself. And in sharing their problems with one another, they all understood a great deal more about how the program was working. And they also found they could all help one another more; so the person in the agricultural extension office could do something for the family planning person while doing field work. And the family planning person could promote certain agricultural or cooperative ventures when working in the field. Because they learned much more about the other programs, the flow of information was greatly increased and they could all greatly help promote the other programs. The third thing was a rather unusual thing that happened in this particular program. At each one of these local meetings someone from the upper level would very often be in attendence so the state rural development officer would meet with the district officers during the district meeting. And even the very high officials in fact even the Deputy Prime Minister himself who was running this program went around to all the districts and visited them at least once a year and sat in with their district rural development committees meetings. So we received very strong political input from the top - even from the state levels - all the way down to the lowest levels. And what was happening was the government from the top was pushing these local committees to set ambitious targets and to work very hard; pushing them along while making sure they were doing the job and providing some control over them. But they were also bringing help and bringing resources so that if the local program was stopped because funds from above were being blocked, someone from above could loosen those funds and make them flow. If they were blocked

because they could not get an order for a certain piece of land administration done, then someone from above could give them some help to make these things go.

So from up above, from the leaders, they got both the push to work and also the assistance to work. And when that happened, the people at the lower levels recognized that there was a great deal of pressure on them to really work. But they also began to have a lot of confidence in themselves. They felt if they really did go out and work hard, really did try hard, then they would get help from the top and they could move their programs very well. So that program in Malaysia worked very nicely with having lower level meetings, setting the targets, explaining the problems to one another, and having this input and support from the top. In the Korean setting, this might mean someone from the provincial level would work with the counties very closely in setting up meetings, deciding what would happen in those meetings, and helping to get resources from the provincial level down to the county level, which could then go down to the township level, with each level from the top pushing on those below but at the same time also providing a lot of support.

Perhaps the final thing that should be said about this is that, that kind of effort to build meetings and to build programs helped to break down some of the boundaries between the agencies. Very often we find that people in one agency, in agriculture for example, may not be very concerned with how family planning is going. Or the family planning people may feel that what goes on in drainage and irrigation or agriculture is not their affair. So that if we fail in agriculture it does not matter; it's what happens in family planning that matters. When you build

a successful integrated program, then you make everyone at the township level or every one at the county level feel responsible for the way everything goes. So then family planning people are feeling responsible for agriculture and public works and education and education people are feeling responsible for family planning and agriculture; and then they are providing a great deal of help and support for each other. You are breaking down the bureaucratic boundaries between the agencies and building a lot of cooperation at the lower level. And when you can build cooperation at the lower level, you will get a lot back from the workers for the amount of effort needed to create such cooperation.

As a closing word; I said at the beginning that Korea had played a leading role in economic development, family planning, and in beginning integrated development programs. I fully expect that over the next year or two Korea will also continue to demonstrate that position of leadership in building a very effective integrated rural development and family planning program. Because of the things you have done in the past and also because of your Korean Institute for Family Planning (on which all of you can draw for support and assistance) which has one of the best records for doing good research, knowing what to do about research and paying attention to organizational affairs, I am sure that if you work with KIFP Dr. Han and Dr. Kim in seeking solutions for your organizational problems in the field, you will receive assistance and be able to solve the problems.

PART II

FAMILY PLANNING PROGRAM MANAGEMENT ADMINISTRATION THROUGH SYSTEM APPROACH

Bark, Dong Suh Ph.D.*

CHAPTER 4

The Role of the Executive Manager of Family Planning Program

The purpose of this paper will be the analysis and description of the role of the executive manager of the family planning program in Korea. The concept of the role will be here defined as the expected behavior by those who have the functional relationship, in this definition two features are emphasized: 1) expectations (i. e., beliefs, cognitions) held by certain persons in regard to what behaviors are appropriate for the occupant of a given position, and 2) enactments (i. e., conduct) of a person who is assigned to, or elects to enter, a given position.[1] The concrete contents of the role of the executive manager will be presented in the following statement.

The executive manager naturally includes those who are

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1) Leonard Broom and Philip Selznick. Sociology Evanston, Row, Peterson and Co., 1956. pp. 98~99.
Encyclopedia of the Social Sciences. Vol. 13. New York, Macmillan, 1954. p. 546.

responsible for the family planning program in Korea, for example, the director and administrative executive of the health center, and employee of the Ministry of Home Affairs who are participating in this training program, I, however, consider the director and administrative executives of the health center as the object of the executive manager mainly.

The executive manager as the professional service has the functional interaction with his superiors, colleagues, subordinates within the organization and also the leaders of various social and professional groups and clients outside the organization to which he belongs.

The roles will be analyzed from the perspectives of the administrative process as follows: the formulation of goal, policy-making, planning (organization and resources), motivating, control and feedback.

THE FORMULATION OF GOALS

The most important role as the director or executive manager will be the formulation of goals which will be attained by the agency for which they are responsible, when they consider the development of organizational performance seriously.

The goals will be differentiated from the ideal which is not generally realized in the near future. Some people further differentiate goals, objectives and targets according to the concreteness of the contents hierarchicaly, I, however, do not here do it in detail.

The function of goals will be enumerated as follows[2]:

2) Garth N. Jones. Planned Organizational Change. London, Routledge and Kegan, 1969. p. 135.

1. It provides the guidelines for the future development and action.
2. It also provides the legitimacy for the existence of the organization by announcing what they are going to contribute to the society and the welfare of the public.
3. It provides the criteria of evaluation of the organizational performance, which is very crucial for further development of the organizational effectiveness continuously.

The method to formulate the goals will be classified into three ways, when we observe the actual practices.

1. The authoritarian way: it means the decision made by the director without much consultation with other people immediately after he was placed at the post.
2. The traditional way: it means the director does not recognize the importance and function of the organizational goals, so that he does not formulate the goals and announce the goals formally.
3. The rational way: this is the most desirable way, as the director understands the significance of the organizational goals and plan to formulate the goals through getting the information and ideas from his subordinates and also clienteles, leaders of social groups, and experts outside the organization who are much concerned with the organizational performance.

It will be desirable to understand the present situation accurately, perceive the major problems, and identify the desires of the employees, clienteles and the formal goals of the organization, and finally try to integrate the individual goals and formal organizational goals.

Finally it must be announced widely to those who are within and outside the health center. The director also has to try to make all the employees commit to the stated

goals strongly in order to attain the developmental goals successfully, otherwise it will be hard to expect the goals will be realized by the ordinary bureaucrats.

POLICY-MAKING

In general the various events will be happened round the office of the executive manager, some of these events require their decision to solve the problems, which include the decision to guide the general direction of future change and to judge the particular case on the basis of the rules enacted in the past.

Here I discuss the former as the main responsibility of the executive manager, as the latter will be delegated to the subordinate as programed and routine cases.[3]

It has been criticized quite often in the past that the policy-maker in Korea decides the major policy on the spot in authoritarian way, therefore they have to revise those decisions made a few months ago, otherwise the administration will be carried out in the formalistic way. I believe how to make the rational decision will be the most important concern for the policy-maker, the following three methods will be helpful for them.

1. Participants as the anti-authoritarian way.

The policy-making process draws on the advice and participation of the following groups.

a. the subordinate as expert or those who understand the implementation problem well and reality on the contact or interrelationship between the office and the public.

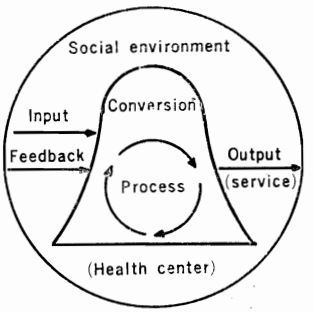
3) Herbert A. Simon. *The New Science of Management Decision.* New York, Harper, 1960. pp. 55~57.

b. the expert when the problems demand the specialized knowledge and skills which the subordinate does not have.

c. clienteles and interest groups as those people understand the reality the most and also have the direct interest in the policy the most, though they sometimes insists on a particular or special interest in order to maximize their own interests. We have to remember those policies made without their participation will be inapplicable ones, which have been quite often happened in the past and today.

d. leaders of various social groups and agencies for the sake of popular support and making the environment favorable for the agency, as the administrative agency will not be operated without environmental support and also has many kinds of functional linkages with environment laterally and hierarchicaly as described in the models:

Figure 1. Administrative Organizational and Enviornment



2. Decision-process as anti-on the spot.

The policy-making process follows a clear-cut decision

process. It will be analyzed into various number of steps according to the preference of the analyst, I, however, divide the process into the following four stages:

a. Perception of the problem.

All the executive managers face the difficulty which select the problem to solve among many events happened in and outside the office. Such a selection will depend on the perception of the problem, which will be influenced by his own subjective judgement based on values and motives.

b. Collection and analysis of the information.

We have to collect the information on the selected problem in order to devise the rational solution and analyze them. Unfortunately, very few agencies are equiped with the depository of those information and reference at present in Korea.

c. Working out the alternatives and their evaluation.

It is highly necessary to exercise the so-called the management science techniques on this stage.[4] I would like to emphasize strongly that all the executive managers should recognize the importance of system analysis perspectives at least in order to devise the rational and effective ways to promote the organizational performance as a whole.

d. The final selection will be done by the director with political consideration.

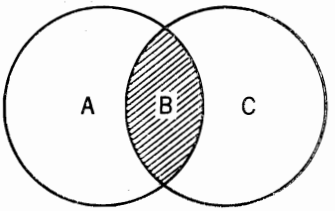
3. Public interest as normative criteria. (anti-bureaucratic interest)[5]

4) Chi-Yuen Wu. "Operation Research for Developing Nation", *International Review of Administrative Science*. Vol. 36, No. 2. 1970. pp. 101~102.

5) Bark, D.S. "Policy-Making and the Public Interest", *Korean Journal of Public Administration*. Vol. 13, No. 1. 1975. pp. 46~60.

It is very often heard that the government employee promotes the public interest formally, however, it is severely criticized by the people and we are often disappointed when we observe the effective behavior was bureaucratic interest oriented. The most realistic and acceptable definition of public interest will be integration between the formal goal of the office and interests of the clienteles and employees.

Figure 2. Relationship between Public Interest and Private Interest



A=Public interest which is not coincide with private interst.

B=Integrated interests and desirable policy line.

C=Private interest which does not contribute to public interest.

We found some government officials consider the public interest in entirely different from the private interest from the view points of collectivism inherited from the traditional culture of Confucianism. Such a collective perspectives lead to the formulation of the unrealistic and unacceptable policy which is against the private interest.

PLANNING

It is mainly concerned with the methods and concrete procedure of the implementation of the policy and program. I discuss here the problems of organization or differentiation and resources as major tools.

Organizing

The organizing implies not only the specialization and integration horizontally and vertically, but also the linkages with various organization in the environment. Especially the peculiar problem for the health center under dual supervision of the Ministry of Health and Social Welfare and Home Affairs, the latter actually exercise the strong influence over the center, though the Ministry does not pay due attention to the health program in the past. Therefore, the executive manager has to work out the ways to attract the more attention of these influentials in the MHA through various means, for example, regular visits, more frequent communication, invitation to the center, demonstration of the achievement of the center etc.

Resources

The kinds of resources includes the manpower, finance, political support. The first concern for the development administrator will be the mobilization of these resources, for example, the manager has to do the best to mobilize more finance, more and qualified manpower, and promote the strong political support from the superior, subordinates, the clientele, mass communication, other government agencies within the districts, and the public outside the organization, when he plans to do new tasks and even the routine works better than in the past. The urgent problem is to turn many temporary female employees into the classified service and complement the shortage of the finance caused by the elimination of the informal financial mobilization in the past.

The next step will be allocation of those resources. We

have to decide the priority of many programs as criteria of allocation, otherwise, it will lead to the waste of the scarce resources and misallocation. The previously mentioned management science techniques and system analysis will be highly necessary for the administration at this stage of decision, which has been neglected so far. Therefore we have often found the cases which the resources were allocated to programs to the contrary of the priority or the weight calculated from the viewpoint of contribution to the organizational performance. Naturally, those employees in the line of main health care service must be considered prior to those in the administrative staff whose duties are supposed to help and support the line.

MOTIVATING

This is the most serious problems and bottlenecks faced by the center and its managers together with the support from MOHA. Many factors are involved to promote the motivation such as the leadership, communication, human relations, and compensation.

1. Leadership

Traditionally the administrative leadership has not been democratic, but exploitative and authoritarian, so that the most important matter will be the self-sacrificing leadership, which implies the fair allocation of values among employees within the organization and also allocation of more values to employees through the endeavour to mobilize various kinds of values at first. It seems to me it will not be achieved in Korean administrative culture if the director does not try to do it very hard intentionally and exercise the self control and discipline by himself.

There had been conflicts between the professionals in the medical service and administrative or clerical service on the one hand, conflicts between those who are engaged in the control function over sanitation service and medical service on the other for the long time, as the medical service had been neglected and did get the support of the superior to the contrary of the organization goal, however it had been reformed since last year when the service in the field of the sanitation had been transferred from the health center to MOHA.

2. Fair and just evaluation of employees' performance, and appropriate reward according to the contribution to the organizational goal attainment. The contents of the reward will be dicided to the basic needs of employees as mentioned by Alport P. Maslow long time ago.

However, the important point is that the satisfaction of the basic needs does not come first as insisted by Maslow, because it is almost impossible to satisfy the inflated expectation of the people in developing nations stimulated by the demonstration effects and also it is doubtful that satisfied employees will be always motivated highly.[6]

3. Vertical communication from the bottom who has frequently contact with the clienteles not in the favored social stratification. We have to be aware that the tenure of the temporary employee is not secured and the hierarchical structure are not favorable to vertical communication, in addition to this most clienteles are in lower stratification and inclined to complain and be critical against the service, so that the director especially try hard

6) Charles D. Raruser. "Performance, Satisfaction, Effort", Personnel Administration and Public Personnel Review. Vol. 1, No. 1, July~Aug., 1972. pp. 1~5.

to get true information and opinion by himself intentionally.

. Support and encouragement[7]

This especially required in the case of the health service, because the health service in general in Korea has not been considered as important program by the government employee on the whole, particularly by the employee of MOHA, so that the employee of health center has been faced with difficulty to get the help and coordination from other related administrative agencies. The executive manager has to seek the assistance actively from other agencies and encourage his subordinates to make his subordinate carry out their tasks faithfully as scheduled.

CONTROL AND FEEDBACK

It is necessary for any human organization to be equipped with the control and feedback mechanism, as all the human being in the organization might behave different from the ordered or planned way of action. It could happen even in the case of machine system, the organization men who have various kinds of emotion values and information each other could lead to wrong behavior easily as we experience every day within the organization. Sometimes the subordinates carry out the order as planned, but the implementation came to cease to move forward the final stage or move entirely different direction from instruction.

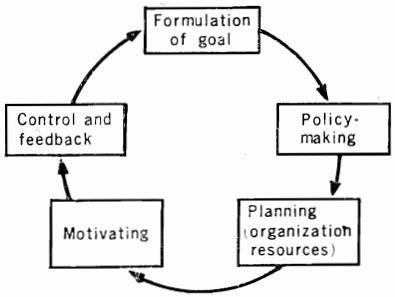
Therefore, we need to have the organizational structure responsible for the control in order to secure the implement-

7) Han, Dae-Woo. Leadership and Organizational Effectiveness in the Korean Family Planning Program. P.H.D. Dissertation, University of Michigan. 1974. pp. 16~20.

ation as instructed or planned. The director must be all the time careful to the control function himself if he does not have the separate organization structure as common in the small organization, he has to try to review and analyze the implementation process, and find out the problems involved in the process of implementation and the functional consequence, then take the action to make all the planned programs be carried out as scheduled, and inform all the employees of the results of control as feedback function.

In Korea we did not have even the concept of control and feedback occupying the important stage in the administrative process for the improvement of the organizational effectiveness and efficiency until 1961, so that some administrators still neglect the control and feedback function today when it has been 15 years since its introduction. Now we come to view the administration as the circular process from the formulation to the control and feedback when we include the control and feedback. Each stage is mutually related as a system functioned dynamically within larger environmental system.

Figure 3. Administrative Process



Whang, In-Joung Ph.D.*

CHAPTER 5

An Operational Framework for Management of Comprehensive Family Planning Program

This study attempts to make an operational conceptualization of family planning program implementation in order that managers of family planning (FP) programs may understand more fully what activities need to be performed by them and why, and how such activities are related to one another as well as to the program objectives themselves. In other words, the aim of this study is a systematic identification of activities in terms of their specific objectives and their inter-relationships. It will provide a basis, for managers and administrators of FP programs, through which to introduce a system of management by objectives (Humble, 1967; Odiorne, 1965; Schler, 1961) at every aspect of program implementation. It is also hoped that this paper will provide a guide to managers and administrators re-

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garding their actual commitment, the role and pattern of involvement of coordinating agencies, the mobilization of manpower as well as financial resources. Furthermore, it is intended that the definition of activities and tasks by their specific objectives in this study will facilitate a clearer understanding of why managers should do certain things, thus leading to a more satisfactory appraisal of alternative courses of management action within given constraints.

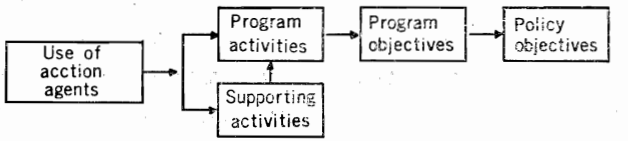
The activities and tasks of a FP program can be classified into two broad categories: (i) program activities which are directly relevant to the achievement of program objectives (e.g. information-education-communication, logistics-supply), and (ii) supporting activities which are facilitative to the performance of program activities (e.g. organizing, training, budgeting, research). Program activities are derived from the objectives on the assumption that the objectives can be achieved through the performance of such activities. Supporting activities contribute and stimulate, directly and indirectly, organizational performance in order to get program activities accomplished thus leading to the achievement of program objectives. But, the results of supporting activities themselves do not necessarily reflect program performance.

The management of family planning programs means getting both types of activities performed through coordination with appropriate action agents. The action agents include not only managers themselves and their subordinates or lower-order organizational units under their direct supervision, but also other governmental and even private organizations which are directly or indirectly related and which could be utilized for the programs.

Consequently, this paper will also identify such action

agents available for particular activities.

Figure 1. Action Components of Implementation Systems for Family Planning Programs



This paper will discuss program activities, supporting activities, and action agents as main components of the implementation systems for FP programs. The relationship among the three in terms of their contribution to the attainment of program objectives and in turn to policy objectives is shown in Figure 1. The feedback process between these components should be born in mind.

PROGRAM ACTIVITIES

Generally, the objectives of a FP program tend to be broader as the program aims at improvements in health and welfare through better spacing of children and socio-economic development. (Styces, 1974) Nevertheless, it is assumed in this study that from the view point of fertility, a preference for small families and a slower rate of population growth will be a primary step in enhancing levels of health and welfare in general, in providing a higher standard of education, and in facilitating economic and social development.

Therefore, it can be stated that the objective of a FP program, in simple terms, is to reduce the fertility rate of the population. However, such a definition of the program objective hardly serves as a guide to the management of FP programs. The term "fertility reduction" itself should be restated in behavioral terms to include specifications of who, what, where, when, and how-so as to serve as a management guide to managers and administrators in family planning on the basic of the assumption that FP practice is a determinant of fertility change.[1)]

In behavioral terms, it can be restated that the primary objective of FP programs is to make people accept FP ideas and methods, and continue the practice.[2)] However, the objective is not only the acceptance FP methods or the practice of contraceptive behavior by eligible couples alone; it is also the real impact family planning will have on the fertility of the population as a whole. In other words, the objective is not simply that of reaching the numerical target of FP acceptance among any group because FP practice by those who do not want any more children after having had a considerable number would in itself contribute little to the desired reduction in fertility rate of a society.

Now, such behavioral expression of the program objective would help the managers of FP programs to understand more clearly what is expected of them. However, the capacity of the expression as a managerial guide (in practical terms) is still limited, unless the program objectives is elabor-

1) Other determinants of fertility change are, for examples, later age of marriage which affects nuptiality(Freymann, 1975), education level, income-level, employment pattern, etc.

2) The term to get things done will be consistently used hereafter to describe activities which should be performed by managers and administrators.

ated into specific operational sub-objectives which would be instrumental to the former. In other words, it is desirable to develop a cluster of next-order objectives in terms of means-end analysis.

In fact, acceptance of FP methods and services means behavioral change of individual clients. There are three basic inter-related determinants of human behavior: (i) internationalized values and motivation of individual clients, (ii) availability of necessary technology (e.g. surgical services, pills, condoms), and (iii) environmental constraints (Morris, 1956; Kluckhon, 1961; Parsons & Shills, 1951).

Therefore, these above mentioned variables which influence program objectives, can be further elaborated into the following specific sub-objectives:

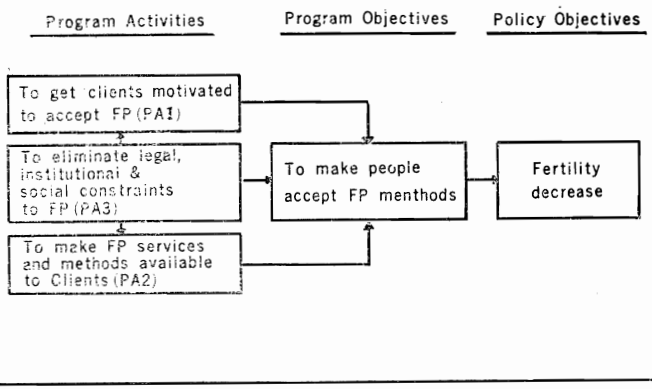
(a) To motivate the clientele groups to accept FP ideas and methods suggested in the program. The activities developed in this respect would be called INFORMATION-MOTIVATION ACTIVITIES (PA1).

(b) To make FP methods and services available to the clientele groups. The activities relating to this would be called LOGISTICS-SUPPLY ACTIVITIES (PA2).

(c) To remove legal, institutional and socio-cultural constraints to acceptance and continuation of FP behaviour by clientele groups and to provide institutional incentives to FP people who are motivated to accept FP methods must not feel any sense of guilty——ethically, morally or legally——about their practice of contraception; rather they should regard it positively. The activities organized for the attainment of this objective may be called LEGAL-INSTITUTIONAL ACTIVITIES (PA3).

Figure 2 shows the inter-relationships among the three

Figure 2. Components of Program Activities



sub-objectives which become a conceptual base for organizing government activities towards a "client-centered" family planning program.(Simons et.al.,1975) The extent of emphasis accorded by government policy to any particular sub-objective depends on the priorities in FP program strategies based on the country situation. Nevertheless, in actual situations, most of the national FP programs can be regarded as a mixture of the three sub-objectives and their accorded activities. The pattern of such activity-mix seems to be a matter of varying emphasis among objectives rather than variations of objectives themselves. In other words, each of the above three activities as well as various combination of them could be regarded as alternatives for the pattern of national programs on fertility reduction. As such, the right activity - mix should vary in the pattern, as the program evolves over time.

Information-Motivation Activities (PA1)

Information-motivation activities are well covered under "public information, education, and communication" (IEC) activities of FP programs (Johnson, et. al. 1973), which assist in creating demand for FP methods and services. Since the acceptance of family planning(behavior) by clientele is realised only when demand is met by supply, the creation of the demand for, and the supply of FP methods and services should be considered together in the actual operation of the programs at field level. However, for analytical purposes, as well as for the specification of these activities, they will be discussed separately.

IEC activities are aimed at influencing human behavior to bring about a large-scale reduction of fertility in the community through the persuasive dissemination of FP ideas. They are basically oriented to the motivation of clients since motivation is presumed to be basic to behavioral change which will be manifested in individual action. To get clientele groups motivated to accept FP ideas and to practice FP methods appears to be a most exacting task in the successful implementation of a FP program. In developing systematic sets of cause-effect relationships among factors and variables in the process of human motivation and perceptual change, existing knowledge and theories are limited. Therefore it is difficult, and possibly even dangerous, to elaborate systems for motivation activities in the form of inflexible hierarchical relationships. Nevertheless, there is no doubt that such an exercise will be a useful base for a more systematic conceptualization of IEC activities, provided we allow some flexibility.

For an individual to be motivated to adopt certain behaviour, there are three basic conditions: (i) he (or she) must be aware of it; (ii) he (or she) must be convinced that it will be of relative benefit; and (iii) the community mood (social environment) must be favourable and tolerant towards it (for a similar theory, see Zaltman, 1973 pp.60~66.) Therefore, the motivation activities in FP programs involve the following:

(PA1.1) To get clientele groups informed about family planning ideas-i.e. KNOWLEDGE/INFORMATION at societal as well as individual levels.

(PA1.2) To get clientele groups convinced that family planning is worth adopting and is necessary to them as individuals as well as members of the society (or to get clientele groups to form their favourable attitudes towords family planning),-i.e. PERSUASION / ATTITUDE FORMATION activities at individual level.

(PA1.3) To get societal and community mood favourable to, and tolerant of family planning behavior. i.e. NORM CHANGING activities at social-community level.

Each of these will be elaborated further into specific activities by referring to their objectives, as follows:

Knowledge/Information Activities at Individual and Social Levels (PA1.1)

Activities required to get client groups informed about FP ideas and methods may be elaborated in terms of four components of the communication model (Deutch, 1966; Rogers, 1973): receiver (clients), message (symbol and contents) channel (media), and source(individuals organizing the message). The strategic programing of information activities by the central administration of FP programs

would start with the following major activities:

(a) To get clientele groups identified and classified into various categories[3] in terms of socio-economic status, profession, urban/rural settlement, education level, religious/ethnic grouping, pattern of media accessibility, perceptual pattern (if possible), etc.,—client-segmentation. (Roberto, 1974)

(b) To get messages formed so as to be persuasive to respective clientele groups by organizing appropriate,[4] and mobilizing readily indentifiable languages and terminology, symbols, etc.—message formation.

(c) To get, from all available media, adequate communication media (channels) selected and organized for respective client groups, in terms of accessibility, perception terms and credibility, time, place, economic as well as social costs, etc.—media selection.

(d) To get the communication sources to work more effectively. This would include the following:

(i) specific identification of various kinds of communication sources available such as FP field workers, para-medical workers, informal community leaders, etc. (See pp.133—144 of this paper);

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3) The clientele groups IEC activities should cover not only eligible couples but also other categories of the population such as informal opinion leaders, community leaders and students, while the client groups for supply activities cover only eligible couples in relation to the available FP technology and policy.

4) The message content in FP information activities should include FP ideas and methods, economic and socio-psychological costs, consequences and benefits explained to clients in relation to their own desires and interests, and compatable with existing values and norms, availability of FP service and instruments (where and how), fertility behaviour of their reference group, if available etc. (Rogers, 1973)

(ii) development of strategies for building and maintaining credibility of and accessibility to the communication sources; and

(iii) establishment of feedback mechanisms for communication activities.

Persuasion/Attitude Formation Activities at Individual Level (PA 1.2)

Knowledge/information activities are aimed at a change in the attitude of clients and eventually a change in their behavior. However, it may be dangerous to assume that information activities will spontaneously lead to attitude formation of clients as intended by managers of FP program. Therefore, rigorous efforts must be made on the part of administrators in order to get clientele groups convinced that FP is not only worth adopting but is also necessary, by making them understand fully the necessary methods and by evoking their felt-needs. This is the process of persuasion of clientele groups in order to make them form a positive attitude[5] towards FP. (Crawford 1974, pp. 223~230)

The process of attitude change with regard to FP behavior would be dependent upon four major factors: (i) ability of FP workers to persuade clients; (ii) institutional arrangements for repetitive client contacts and organizational follow-up; (iii) strategies for peer group pressure, if adequate, and reference building; and (iv) well-organized messages.

5) It is noted that attitude must be understood as "a premise of action" which leads to a presumed action. However, attitude revealed in most of KAP survey is more likely to be a part of extended knowledge of respondents as a consequence of mass communication campaigns of FP in developing countries. (See also Cleland, 1973)

Therefore, the activities for attitude formation can be expanded into the following:

(a) To get FP workers to identify and differentiate their clients in terms of clients' capacity to understand (or level of education) and degree of open-mindedness (or receptiveness to new ideas)—differentiation of clients for person-to-person approach (at individual level).

(b) To get FP workers perceptually identical with their clients and accessible to them in a friendly way—perceptual apprcach[6] (Singer, 1973).

(c) To get FP workers capable in the manipulation of messages. If necessary, they should be able to demonstrate the relative advantages of FP in terms of tangible and visible benefits in a broad context,[7] to inject the feeling of threat, or to convince them of the disadvantages of a "large number of children" etc.

(d) To get FP workers to contact clients frequently with consistent information, by providing incentive measures on the one hand and by supervising their performance on the other.

(e) To get adequate strategies developed for generating a sense of group pressure among clients, if necessary.

(f) To get the acceptance of FP by reference groups

6) This will be considered as a factor to be reflected in recruitment policy of FP workers or motivators as well as in training programmes.

7) This will cover, for example, comparative advantages of small family in a particular social systems and implications in connection with tax, education, housing, welfare policies, urban life, etc. especially for the resistant clients. This aspect of FP workers' capability can be considered as a factor to be reflected in the training program of FP motivators and field workers. Such training programe must reflect the idea that self-confidence and enthusiasm (Goldman, 1973) of FP workers are important conditions in making clients convinced.

contained and conveyed in the messages for respective client groups. Reference groups would be those with status, power and authority, formal/informal leaders, modern/traditional elite, community leaders, leaders of peer groups, etc.

Norm Changing Activities at Social-Community Level (PA1.3)

The above two sets of activities for information and attitude change are organized for administrative action so as to influence those factors at the level affecting FP behavior. The activities to get societal and community mood favourable to and tolerant of FP are related to changes in social norms which are factors at the community and societal level affecting FP behavior. Norms are defined as established behavior patterns for any member of a society, which delineate a range of tolerable behavior and which serve as a guide or standard for the members of that society. The social norms related to FP behavior are primarily small family norm and boy-girl equi-preference norm.[8]

In most developing countries, it seems relatively easier to build the small family norm than the boy-girl equi-preference norm. There is no doubt that change in norms and values cannot take place within a short period because this involves cultural change (Devries, 1966; Sorokin, 1943). Thus, governments must initiate, from the very beginning of any FP program, long-term plans of action with regard to this set of activities. This issue will be further discussed in

8) Because preference for male children is culturally (and even sub-consciously) predominant in the Asian region, the boy-girl equi-preference norm seems to be one of the critical factors which will facilitate FP behavior.

connection with legal-institutional activities (PA3).

However, it may be possible for FP managers to think of some approaches to tackling this difficult task. The hypothetical means to this end could be as follows:

(a) To get formal/school education systems involved in the diffusion of the small family norm and the boy-girl equi-preference norm in terms of curricula development, methodology, policy and content of education programs. (This would require solid support from a well-rounded series of systematic researches on the subject).

(b) To get social security policies to support the desirability of small family and boy-girl equi-preference norms with regard to job opportunities, income, education opportunities, male role in family success. (These are also related to issues in legal-institutional activities (PA3) of FP program management).

(c) To get the existing community/adult education program involved in diffusion of small family and boy-girl equi-preference norms, other related values and specific information about FP.

(d) To get change agents or other community extension workers directly and explicitly involved in discussion of FP ideas and related norms.

(e) To get opinion leaders and informal leadership to form/express favourable opinions regarding small family size, social role of women in coming generations, negative relationship between children and social security of old age, etc.

(f) To get peer groups[9] formed such that they share the new norms.

9) For example, Community-Based Mothers' Club in Korea. (Kim, Ross, et. al., 1970)

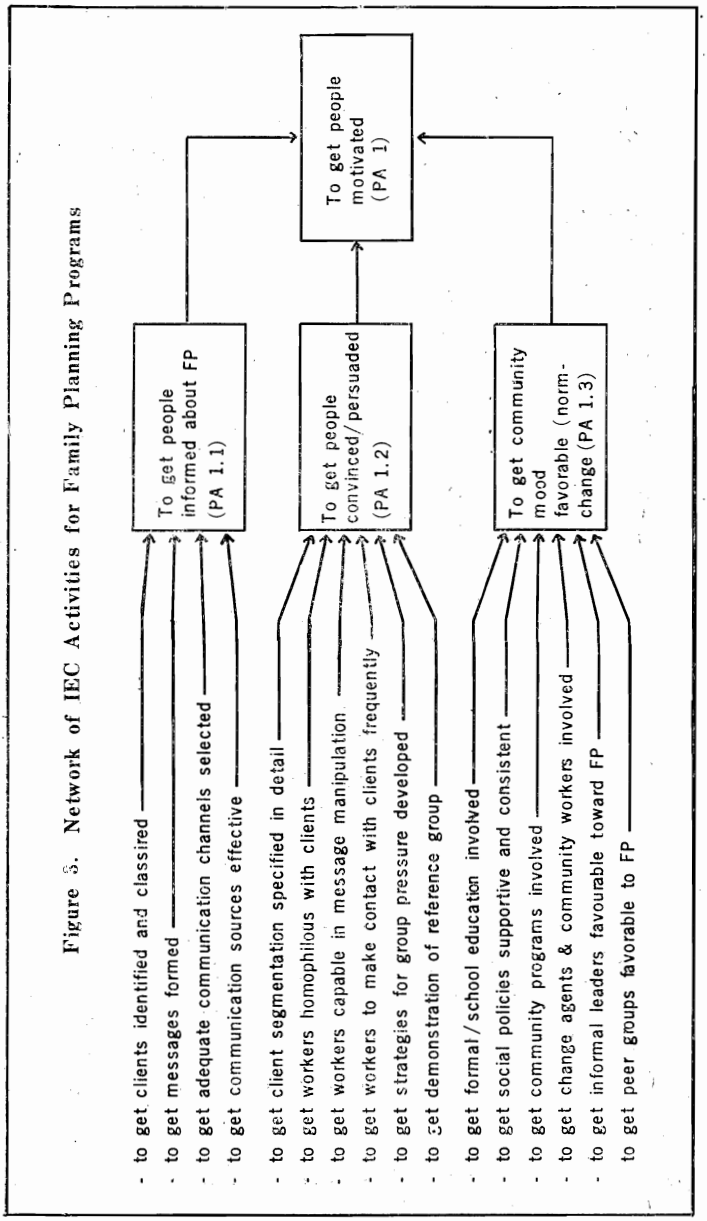


Figure 3. Network of IEC Activities for Family Planning Programs

(g) To get tightly structured organizations formed for diffusion of norms relevant to FP promotion as well as for discouraging existing norms which are contrary to FP[10]

Logistics-Supply Activities (PA2)

Others crucial activities in the managemet of FP programs are the logistics and supply management of FP instruments and services in order to meet the demand of both manifested and potential clientele groups. Whatever the level of motivation of clientele groups to adopt FP ideas and techniques, FP instruments and services necessary for particular FP methods must be readily available to clientele groups. The less motivated the clients are, the more rigorous the effort required to make FP instruments and services available to them. Most FP programs in developing countries are oriented to these logistics and supply activities, especially in the initial stages. Thus, the activities are relatively well-defined but they may still require systematic attention. (Keeny, 1972)

The availability of FP instruments and services depends, however, on the extent to which such instruments and services are easily accessible to the clientele groups in terms of their quantum and quality, location, time and economic as well as socio-psychological costs. Therefore, activities organized to get FP instruments and services available to clientele groups should consist of the following systems of activities at the central level:

(PA2. 1) To get FP methods (including instruments and

10) The traditional values of the importance of male children and of large-sized families are now criticized as "feudalistic" in Modern China (Faundes and Luckainen, 1972).

services) identified and defined;

(PA2.2) To get sufficient amount and reliable quality of FP instruments and services available to the clients;

(PA2.3) To get FP instruments and services available to clients in the most appropriate places;

(PA2.4) To get FP instruments and services available to clients at the most appropriate time;

(PA2.5) To get FP instruments and services available to clients at the most reasonable prices and costs; and

(PA2.6) To get FP instruments and services available without any psychological embarrassment and disturbance to the privacy of clients.

Each of the above will be further elaborated into specific activities by referring to their objectives as follows. These should be meaningful to managers who should make decisions and act accordingly.

Identification of Family Planning Methods (PA2.1)

Activities organized to identify and define available FP methods (including services and instruments) constitute the initial tasks of logistics-supply activities of FP programs. They are the medical/technical aspects of FP and thus require support from systematically arranged research and evaluation. Logically, they consist of the following;

(a) To get both conventional and modern methods of family planning identified and appraised for use in the program;

(b) To get FP methods define so as to be of major concern to the programs and also to get the FP methods specified in terms of FP services and instruments necessary for the methods; and

(c) To get the continuous innovation in and improvement

of FP methods (including instruments and services) instituted in the program policy.

Management of Quantity and Quality (PA2. 2)

The conventional notion of management for logistics-supply activities begins with tasks to make available a sufficient amount and reliable quality of FP instruments and services. This task can be considered in terms of: (a) FP services which require the contribution of professional doctors, such as IUD insertions, prescription of pills, sterilization, etc.; and (b) FP instruments which are "material" in nature, such as condoms, IUD, pills, other medical supplies. Activities to be handled by managers at the central level in order to secure the necessary amount of FP service and instruments world consist of the following:

(a) To get the required amount estimated and the quality of FP instruments and services specified for a certain period of time;
(b) To get a sufficient amount and reliable quality of FP instruments produced by, and procured from, domestic or international producers and agents;
(c) To get appropriate channels arranged for the distribution of FP instruments to clinics and FP field workers;
(d) To get sufficient number of doctors, para-medical personnel and field workers recruited for the FP program network; and
(e) To get FP personnel (including doctors) to allocate sufficient part of their time and effort for FP services.

Geographical Arrangement (PA2. 3)

The next activity—to get FP instruments and services available in appropriate places for the client groups—has

been relatively well—organized so far. The following can be considered as necessary activities to be taken up by FP managers at the central level:

(a) To get a sufficient number of FP clinics or health centres established and operating fully in terms of personnel and equipment;

(b) To get available hospitals and clinics in the organized sector (e.g. military, labor unions etc.) as well as private doctors and clinics identified and to get them involved in the program network;

(c) To get FP clinics allocated geographically in the most appropriate places in terms of population size of community, administrative zoning, transportation facilities, clientele characteristics, etc.;

(d) To get mobile clinics utilized to the maximum extent in the remote villages;

(e) To get FP workers to visit clients frequently and to dispense contraceptives and other services to particular categories of clientele groups; and

(f) To get private/commercial channels (drug stores and home-visiting salesmen) involved in the distribution of FP instruments.

Temporal Arrangement (PA2.4)

Activities to get FP instruments and services available at the most appropriate time for clients are naturally related to the mode of clinic operation and arrangement of places where services will be available. They also depend on the level of motivation of particular clientele groups and community situations. However, the following would be considered as mutually inclusive alternatives;

(a) To get FP clinic services available whenever con-

venient to clientele groups;

(b) To get the most appropriate time during working hours of the clinics, allocated for provision of FP services, when FP is only a part of clinic activities; and

(c) To get FP clinics open at night, if necessary, to dispense FP services and instruments.

Economic and Socio-psychological Costs (PA2.5) (PA2.6)

Attention has always been drawn to the prices and costs of FP services and instruments. Also, various alternatives to pricing policies with regard to FP services and instruments have been developed and adopted in developing countries on the basis of certain assumptions[11] regarding the impact of prices and costs upon acceptance of certain FP methods. These are as follows:

(a) To get certain FP instruments and services provided free of cost;

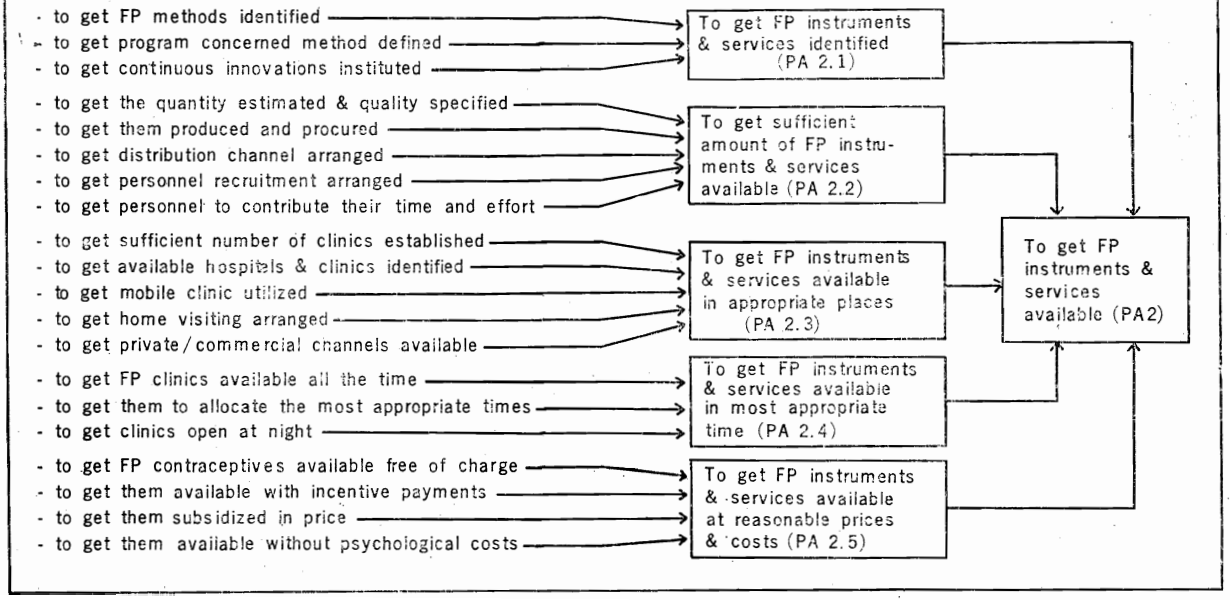
(b) To get certain FP instruments and services provided, paying incentives or compensation to the clients (for example, in the case of sterilization) and

(c) To get the governments to pay subsidies to private and commercial sectors (for example, to keep the price of the condom low).

Activities to get FP instruments and services available without any psychological embarrassment or disturbance of privacy is related to the attitute of clinic personnel, FP

11) It should be noted there seems to be lack of evidence regarding the assumption that the alternative pricing policies are making a different contribution to the level of acceptance. Therefore, it is necessary for FP managers at the central level to get research studies conducted in order to make a rigorous assessment of the impact of pricing policies on psychological aspects as well as on the acceptance/practice level of particular FP methods.

Figure 4. Network of Logistics-Supply Activities for Family Planning Programs



field workers and commercial dealers of FP instruments and services. Therefore, the activities to be undertaken by FP administrators at the central level in order to change the attitude and behavior of FP workers and clinic personnel would require constant support from a systematic and rigorous training program. One possible arrangement for this kind of training would be to organize a training program for all kinds of client-contacting action agents, even those within the private sector. This issue will be further discussed later.

Legal-Institutional Activities (PA3)

The management of every program is bounded by its own environmental constraints. Management of FP programs especially face so many constraints and barriers, known and unknown, which confine the range of program activities and also the volume, speed and direction of action for the implementation of program activities. However, governmental action for elimination of legal-institutional as well as socio-cultural constraints and limitations has not so far involved FP managerial echelons seriously. FP managers and administrators therefore generally tend to perceive these activities as uncontrollable or given factors in FP programs. It also tends to be assumed that national population policy goals can be attained if FP programs simply provide contraceptive services and conduct FP/IEC activities, without including social, structural and institutional changes.

Therefore, it is absolutely necessary for managers and administrators of FP programs to make deliberate efforts to eliminate constraints of this nature as they are a most crucial aspect of FP program management. Managerial con-

cern for such activity has partly been considered in terms of "beyond family planning" policies (Berelson, 1969) which leads to the establishment of supportive links with other socio-economic policies such as all kinds of incentive and disincentive measures in connection with policies regarding taxation, education, housing, maternity benefits, welfare services etc.[12] However, an attempt is made in this paper to develop a list of activities to be organized by FP managers regarding the elimination of constraints and obstacles as far as possible. This includes two sets of activities: (a) reconnaissance and analysis of constraints and (b) action planning for elimination of constraints.

(PA3.1) The identification and analysis of constraints and limitations includes the following:

(a) To identify the most important constraints and limitations (legal, institutional, social, political, cultural, etc.) to the implementation of FP programs. Many of such constraints are already known. But they should be identified and classified in terms of priority of government action.

(b) To identify factors and elements which affect certain constraints and limitations. Managers should identify the factors and elements which may be directly or indirectly controlled by administration.

(c) To identify action agents and instruments. This includes, for example, power, authority, funding, etc. which could be directly or indirectly mobilized to control the factors and elements identified in order to overcome environmental constraints and obstacles.

(PA3.2) Specific action plans necessary to develop both

12) The Singapore case (Wan, 1973) and the Chinese case (Rogers, 1974) would be good examples of such effort. See also chapter 7.

short-term and long-term strategies and policies, and to organize administrative action to cope with constraints and barriers. There are primarily two approaches available: (a) short-term legal approach and (b) long-term social change approach. Change in laws and regulations (e.g. abortion laws, inheritance laws, social security laws, etc.) will be effective in the elimination or deprecation of certain constraints within a relatively short period of time. However, to be effective, action plans for changes in socio-cultural constraints and factors would require consistent and continuous effort for a relatively longer period as norm-building activities (PA1.3) are related to this aspect.

For the successful performance of the above activities, management of FP programs at the central level requires systematic support from rigorous and well planned research and action studies.

SUPPORTING ACTIVITIES

In order to get program activities performed, and thus eventually to achieve the objectives, systematic support from well-defined sets of activities is necessary. Supporting activities for family planning programs are illustrated in terms of: (i) research and evaluation, (ii) staffing and training including career development, (iii) budgeting and financing, and (iv) organizing which includes the establishment of a set of working relationships among action agents and individual members for administrative communication, coordination, supervision etc. Much has already been written on this subject, dealing with theories as well as practice concerning these supporting activities. Therefore,

this paper will seek to clarify only the important aspects thereof on the basis of the characteristics and contents of the FP program activities as discussed above.

Research and Evaluation (SA1)

Research (SA1.1) is an action process to provide knowledge and information which are necessary to strengthen the systems of action for the attainment of program objectives. It is to bridge some information gaps regarding substantial as well as managerial aspects of the program. In other words, research is a process to produce additional information which will answer certain questions and problems of practitioners. Therefore, the objectives of research are as follows:

(a) to identify and verify certain functional relationships between factors (or elements) which are related to operation of FP programs;

(b) to assess the extent to which certain components (or factors) of organizational activities have contributed to the achievement of program objectives (Suchman, 1967 and Weist, 1972); and

(c) to identify and clarify problems and to develop alternative solutions relevant to the problems.

In order to achieve the research objectives considered from the perspective of marketing research (Farley and Leavitt, 1973), the following activities should be performed in planning of the research at the top (central) level of program administration:

(a) To get research needs identified in terms of practitioners' needs: the program director should identify research needs in terms of his own information gaps and hypothetical problems with a view to strengthening

the systems related to program activities, supporting activities and cooperative ties with governmental as well as non-governmental organizations and agencies.

(b) To get the priorities among research needs decided upon particularly for funding: the priorities should be decided upon in terms of the most strategic use of research findings both for routine operation as well as for critical impact upon program operation. The priorities should be accorded in terms of the estimated cost in contrast to utility of possible research finding. The funding should be consistent with research priorities.

(c) To make arrangements for research and coordination: to get research conducted, there are two possible arrangements in terms of responsibility: within or outside the organization (including independent organizations within and outside the government). In the case of a researcher outside the government, there are two possible approaches: contracts and grants. Whatever the formalities may be, the following should be kept in mind by decision makers:

(i) whether the arrangements are adequate enough to convey the research needs and priorities clearly to researchers, in order to avoid the inertia of "research for the sake of research".

(ii) whether the arrangements are adequate enough to make researchers understand who the "end-users" of the research findings would be, so that the research may actually be communicated to the practitioners for their use.

(d) To identify the end-users of the research and communicate the research findings to them: once research is finalized, it must be utilized for appropriate action.

Unless the information provided through research is communicated to the right persons, the utilization of research is limited and in some cases the research becomes a waste of resources.

(e) To get the completed research evaluated; in order to improve research activity, evaluation of research systems for a particular research project should be made, formally or informally, at the program director's level in view of administrators and implementors' interests having to safeguarded adequately at the appropriate time.

Evaluation (SA1.2) of program performance is an action process aimed to produce certain information which is necessary to decision-making in terms of the next-round reinforcement or future corrective action for the improvement of the management of any program as a whole. The basic objective of evaluation is to provide the necessary information as to the extent to which certain actions taken would contribute to the attainment of program objectives and hence whether or not any corrective action against certain aspects of program operations would be required. Such information would be used by managers through feedback channels.

Therefore, certain policy guidelines for evaluation and evaluative research (for conceptual base, see Roberto et. al., 1975; and for specific guideline, see FP Evaluation Institute, 1974) should be made at the program director's level before organizing evaluative actions. It will cover the following:

(a) To identify the major aspects and elements of the program to be evaluated: what should be evaluated is closely related to program objectives since evaluation

is related to strategic emphasis on certain activities and program components and/or bottleneck of program implementation. Evaluation of program objectives achieved, evaluation of processes taken, and community assessment could be complementary to each other.

(b) To make a clear definition as to the reasons for evaluating such aspects (or elements) of the program: this will be a guide for the organization of information in evaluation reports for the decision-makers with regard to any corrective action. A clear definition of evaluation objectives will lead to competent expression of evaluation results.

(c) To get adequate methods of evaluation adopted: when to evaluate and how to evaluate depend on what to evaluate and why. Time horizon of evaluation of a certain aspect of program performance would naturally differ from evaluation of another aspect.[13] So do the methods of evaluation in terms of measurement of unit of performance and sources of data (Whang, 1972).

Staffing and Training (SA2)

Staffing comprises two categories of the action process: (i) to secure a certain number of FP workers required for getting the program performed, and (ii) to develop and reinforce their capabilities for performance of their assignments related to program activities or supporting activities.

The first category is related to recruitment as well as to personnel incentive systems, which require the following

13) The evaluation of ultimate objectives, say fertility decrease, should be based on measuring changes in fertility trends by mobilizing demographic data. It cannot be undertaken immediately, but only after a considerable time period (say,at least 5 years).

activities at the central level:

(a) to get required number of FP workers estimated by specific categories classified, in view of required capabilities in performing their jobs;

(b) to get a set of policy alternatives developed for the best recruitment of the right persons (for particular assignments) and

(c) to get a set of incentives developed to enable the staff to commit themselves to their assignments and jobs.

The second category is related to a series of training programs which require following activities (Odiorne, 1970) at the central administration level:

(a) to get training needs identified for FP personnel according to different categories, in terms of: (i) gaps between their actual capabilities and required capabilities in performing their assignments (this can be called a problem-oriented training), and (ii) critical factors related to attainment of program objectives which should be reinforced (this is called reinforcement—oriented training):

(b) to get the purpose of training clearly defined from training needs. It is noted that training purposes are necessarily identical with training needs because one type of training program may not be able to meet the training needs at the same time:

(c) to get training programs developed in terms of content and methodologies in the context of training purpose, training materials, period of training, trainers and trainees, one-shot training or training series, continuous/repetitive training, etc.

(d) to get training institutions arranged. It depends on

the purposes and characteristics of the training program. Available alternatives are similar to institutional arrangements for research activities.

(e) to get training programs systematically reviewed and evaluated in view of the contribution of trainees in actual practice. This will require special skills in observation and careful consideration in selection of the time period as discussed in evaluation of program performance.

Budgeting and Financing (SA3)[14]

Budgeting and financing are action processes to provide authority and funds to organizations and action agents so as to enable them to obtain material as well as manpower resources required for the performance of tasks assigned. Systems approach to budgeting and financing(Novick, 1965; Cutt 1974: Hovey, 1972) requires the following activities at the central level:

(a) to identify who (action agent) needs how much money (cost) and for what (activities);

(b) to define criteria for, and priority in, allocation of budgetary resources among different activities and different organizations responsible for performance of activities. The objectives of the FP program must be strategically reflected in criteria and priority. Cost-benefit analysis could be considered as another criteria:

(c) to make strategic use of budgeting and funds such as special outlay of funds for incentive payments of clients and bonus for family planning workers;

(d) to provide flexibility in budgeting and financing, if

14) Basic notion on rational approach to budgeting is reflected in literature on Planning-Programming-Budgeting-Systems (PPBS).

necessary, beyond bureaucratic control; and

(e) to ensure the timely availability of funds to the program activities at field level.

Organizing (SA4)

In order to get the above activities and tasks performed, program organizers (or managers of the program) must utilize suitable action instruments (agents) including government agencies, voluntary organizations, private/commercial channels, etc. Organizing is an action process to get relevant action agents involved in appropriate stages of program implementation and thus to get them really committed to their work performance. Although organization differs from country to country because of different environmental and cultural settings, it requires in general the following activities:

(a) to get relevant action agents identified in terms of their availability (accessibility by the program organizer) and applicability (capability to perform) to a particular activity, and to assign prime responsibility to an action agent with whom other related agents can cooperate and coordinate[15] with regard to a particular activity.

(b) to get relevant action agents aware of what their jobs are and how their jobs are related to performance of neighbouring activities. This is a matter of the ad-

15) For example, distributing of condoms could be conducted mainly through FP field workers in a country. Nevertheless, a considerable extent of the distribution of condoms may be done through private/commercial channels such as drug stores or home-visiting sales personnel. In such cases, one of the important jobs for FP program managers at a certain level is how to get drug stores and sales personnel continuously involved in this program in coordination with FP field workers.

ministrative communication network and pattern of information flow, and the establishment of working relationships and coordination among action agents. (Whang, 1974)

(c) to get inter-relationships among all the program activities as well as supporting activities closely reflected in the pattern of interaction among action agents (or individual members) to make identical organizational structure with program structure.

(d) to get an adequate amount of authority, power, responsibility and resources (both manpower and materials) allocated to action agents for actually desirable arrangements of central-local relationships (Austin, 1973). The pattern of central-local relationship would be described in terms of centralization versus decentralization. However, in actual practice, the pattern could be developed by combining relevant variables such as power, resource and responsibility (or contributability to program performance).

(e) to get action agents to establish criteria and standards of job performance and performance indicators such that they reflect the objectives of their activities.

ACTION AGENTS

The identification of suitable action agents for a particular activity is an important step for getting the aims and purposes of any FP program successfully accomplished. Whether a particular organization unit serves a single objective or multiple objectives depends on its instrumentality – that is, availability and applicability. In actual practice, most of organized activities based on action agents involved in

FP would serve multiple objectives. In other words, some of the objectives can be incorporated into a set of activities organized on the basis of available action agents in a given circumstance. Overlapping and duplication of activities are necessary and often inevitable. Also multi-purpose action seems more desirable in the actual context of the operation.

From the management point of view, the key to program success is how best to use these action agents and how to secure optimal cooperation and coordination between them in the most flexible way for the implementation of particular activities and tasks. This matter is also related to the distribution of authority and the assignment of responsibilities to particular organizations in terms of central-local arrangement as well as specialization of functions within the organization.

For the successful performance of program activities which requires positive popular support, all available action agents should be identified and mobilized in a way so as to secure their close cooperation. Action agents can be identified in three broad categories—government agencies, voluntary organizations, and private/commercial sectors. The degree and pattern of their involvement and utilization would differ from country to country because of different administrative settings for population policies as well as different cultures. In this paper, action agents are discussed by category of activities as analysed in the preceeding sections.

Action Agents for Information-Motivation Activities

Although administration of IEC activities require specialization, the subject of FP is so concerned with the daily aspects of life that every one may talk about FP and in so

doing may affect IEC activities in one way or another. In communication terms, sources of information with regard to FP are heterogenous and hence uncontrollable by a single administrative authority. The communication pattern of FP as a "taboo communication" (Rogers, 1973, pp 61~67) tends to be an inter-locking network. There is a wide variety of action agents who are either directly or indirectly involved in the communication process and can thus be utilized under the framework of IEC activities. However, for management purposes, it may be helpful to discuss them in major categories. The following list illustrates some of these:

(a) Organizations having prime responsibility for FP activities on information and motivation, and with their local offices and unit branches. The organizational arrangement for IEC activities at the national level reflects policy concern for population and FP issues.

(b) Organizations and agencies responsible for formal education policies and programs (e. g., Ministry or Department of Education). The promotion of the small-family norm as well as the boy-girl equi-preference norm through the formal education program is a most effective measure for the long-run institutionalization of a FP program. This requires constant coordination between the Ministry of Education and the FP agency and may require positive initiatives on the part of FP administrators to seek cooperation.

(c) Other IEC related organizations and agencies concerned with community/adult education, agricultural extension service, mass communication, etc. Regardless of formal organizational structure, IEC activities require the utilization of expertise of each ministry. Since FP

is an integral part of the total development process, FP administrators at the national as well as local levels should try to develop close coordination both at policy-making and implementing stages with ministries of community development, rural extension services, public information and those concerned with other development movements.

(d) Voluntary organizations such as private family planning associations and other social organizations whose activities could be closely linked with social education such as 4H clubs, women's clubs, social welfare organizations, etc. FP program managers and administrators should build a good rapport with such associations which, in most cases, have organized FP activities as pioneering projects before government programs were initiated and thus have already established networks and linkages with clients.

(e) Mass media agencies sponsored by both government and private organizations such as newspapers, news agencies, TV/radio stations, magazines and periodicals, etc. Mass media channels are a most influential tool for a massive communication campaign for the national program.

(f) Local/community leadership, part of which belongs to the formal government network (such as district officers, village heads, mayors, county chiefs, religious leaders, etc.), especially at regional and local levels. They are quite influential especially in establishing community norms.

(g) Individuals or agents related to traditional private face-to-face channels of communication and information flow with regard to family planning, such as peer

groups, midwives and other traditional mass media(e.g. folk theatre, puppet shows, travelling story tellers, balladeers, etc.) must be taken into consideration for use as FP diffusion channels (Rogers, 1975).

Action Agents for Logistics-Supply Activities

From the initial stages, FP programs were mostly oriented to clinic services on the assumption that FP is a medical matter and all of the clients would actively seek family planning services once they are made available. Therefore, most action agents for family planning delivery services were identified and fairly well utilized. Of course, the organization having prime responsibility for logistics-supply activities of the national program is the public health and FP agency network. As FP programs involve a nationwide movement, it becomes necessary to identify and utilize all available agents. These would include the following:

(a) Organizations having prime responsibility for supply of FP instruments and clinic services to clients, such as the Ministry of Health and Family Planning at the center and public clinics at the community level. In most cases, FP clinic services are organized in connection with the existing health delivery systems as an integral part of the health program.

(b) Other special organization units available within the organized sector, such as hospitals and clinics in military, labor organizations, postal service organizations, railway and other public enterprises, etc. The utilization of the organized sector seems to be strategic for FPIEC activities as well as for delivery services in terms of accessibility to kept clients and semi-monopolized services.

(c) Hospitals and clinics operated by voluntary organiza-

tions such FP associations, Red Cross, women's clubs, etc.

(d) Private hospitals and doctors. The contribution of private doctors and hospitals to FP programs would appear to be quite extensive in terms of both their numbers as well as their influence as professionals.

(e) Commercial marketing distribution channels of FP contraceptives such as drug stores, sales personnel and traditional non-professional midwives, etc. The profit motivation of commercial marketing techniques make for greater efficiency in contraceptive sales. Therefore, it seems logical for FP program managers to introduce commercial marketing channels into framework of the national program in one way or another.

(f) On the other hand, the use of traditional agents such as mid-wives should not be neglected, especially in remote villages, because their credibility as well as accessibility to community people based on traditional customs tend to be influential in the supply of FP contraceptives, and because they can be effective agents in spreading unfavourable as well as favourable comments and rumors about the FP program.

Action Agents for Legal-Institutional Activities

Since legal-institutional activities are a part of FP program administration, the FP agency must be responsible for these. However, for the purpose of management, a prime responsibility for the job must be assigned to a particular organizational unit. Also, coordinating agencies with which the FP agency can work together must be identified. These will include:

(a) An organizational unit within the FP agency having

prime responsibility for activities to eliminate the legal-institutional constraints. If such a unit is not available within the organizational framework of the FP agency, the FP program director must be identified as a responsible agent for these activities. Although considerable emphasis has been placed on the need for "beyond family planning" policies, FP managers and administrators tend to believe that such efforts are not within the scope of their administrative responsibilities. Therefore, identification of action agents could be related to the factor of perceptual change of FP administrators and change in program orientation.

(b) Other government ministries and agencies responsible for a particular policy which can be an instrument to legal-institutional activities of the FP program. The FP agency must cooperate closely with the Ministry of Education for changes in educational policies, offering privileges to small family households and re-orientation of education programs with regard to the small family norm and women's education. It must also establish contact with the Ministry of Social Affairs for the acceptance of social welfare policies (e.g. employment policy, women's social status, etc.) which will be favourable to a small family. Identification of such ministries and agencies depends on the subject matter which is related to FP as legal-institutional constraints and/or stimulating factors.

(c) Social voluntary associations or organizations which could be used for the articulation of interests in the process or in the legal enactment or in other institutional arrangements. Identification of such organizations is also important for they can make a professional

contribution as well as assist in the mobilization of political forces in the legal process.

Action Agents for Supporting Activities

Most supporting activities, by their nature, should be undertaken by the FP agency itself. The central office especially has major responsibilities for them and so do the regional/local offices at the intermediate level as they are responsible for the process within the framework provided by the central office. Indeed, the administration at the central office of a FP agency in most developing countries is well-elaborated for supporting activities as it is fairly well-reflected in the structural pattern of the central office. However, it seems quite crucial for FP administrators to retain a good rapport with other ministries which are related to input functions of the agency, such as ministries of finance, planning, budgeting, personnel, procurement, etc. In most cases, program success tends to depend on cooperation among these ministries.

Some special activities like research and training which require more professional and specialized skills and knowledge could be conducted in some cases by professional organizations like university institutions or other separate institutions.

Action agents for research and training could be identified in several alternative forms as follows:

(a) Organization unit within the structure of FP agencies, for example, department of research and/or training having responsibility not only for research and training policies but also for their implementation.

(b) Organization separate from the FP agency such as a government institute of research and/or training having

responsibility for implementation.

(c) Non-governmental independent institute separate from the government program but specialized in training and/or research in FP program.

(d) Other major institutions which can handle research and training in certain areas of the FP programs. The areas to be covered by research and training in FP programs are extremely broad in terms of issues and their complexity. So the identification of suitable institutions which can carry out the required research and training would be the critical step for adequate support to the successful performance of program activities. The above list shows broad categories of action agents which can be identified at the national level. In actual operations of FP program management, more specific agents, either as organizations or individuals, must be identified by FP managers. The identification of such action agents depends on activities which are to be done with the initiative of the managers within their given power and social as well as bureaucratic constraints.

CONCLUSIONS

This paper has attempted to conceptualize the management of FP programs in operational terms by utilizing the deductive approach[16] based on existing knowledge and

16) The deductive approach was utilized here only to establish a framework for the systematic ordering of our observations of existing FP programs and policies and further for the development of adequate action plans by the managers of FP programs. It should be noted that an effort was made to apply the inductive method, though limited, to test the validity of the deductive analysis.

theories. The following have been discussed: what the specific jobs are which should be consciously and vigorously undertaken by managers and administrators of FP programs; how these jobs are related to one another in terms of their functional inter-dependence and eventual contribution to program objectives; what possible action agents are available in view of the socio-cultural context of developing countries, etc.

Analysis of program activities, supporting activities, and relevant action agents from the systems perspective must lead to the development of a certain framework for how to organize them. Although much literature on organizational systems and behavior is already available, the framework here must be developed to fit the actual context of specific activities envisaged by the FP program policy and the available action agents. Therefore, without referring to a particular program, the further exercise of the conceptual framework of program management discussed in this paper may be limited. Further details of the framework for a particular country can be developed in view of specific conditions and constraints in the country. In other words, the framework in this paper may serve as a simple perspective for the development of a specific activity network of a particular national FP program.

Again, this paper is prescriptive rather than explanatory in nature, on the basis of dynamic theories of management and organizational behavior. The matters discussed in the paper may seem too simple to deserve attention, or it may be assumed that they are already understood by FP administrators as basic premises of their programs. Nevertheless, it is argued that, for effectiveness of organizational action, there should be an explicitly common conceptual framework

by which FP program managers and administrators may organize their efforts toward common objectives. In this respect, this paper may serve as a simple framework for action.

It is hoped that this paper will provide an alternative perspective in the assessment of managerial capability of existing systems in FP program management and also a checklist for appropriate action in the improvement of management systems. Furthermore, the framework will be a guideline to the development of management systems of particular administration units for FP programs at every level on the basis of their real situations. Since the framework could be a basic skeleton of action, and in a sense, is part of operational conceptualization, it can be helpful for the elaboration of management sub-systems within the total systems framework, such as management of FP activities at the clinic level, evaluation of the FP program, planning of the FP program, management of research in the FP program, and management of training programs for the national FP programs.

Kim, Kwang-Woong Ph.D*

CHAPTER 6

Empirical Findings of Family Planning Administration Study

The aim of this study was to develop simple and effective measures of family planning programme performance, and to identify determinants of performance, especially among those programme characteristics over which administrators have some control. Behind this simple statement of aims lie a series of assumptions and considerations that can be briefly spelt out here. First, it is recognized that the problem of high fertility facing most developing nations will not be solved by government family planning programmes alone. Nonetheless, these programmes can be of considerable significance in reducing fertility, largely by providing better and fuller family planning services to the population. Second, the programme is seen as an organization that is deliberately established with a major aim of reducing fertility through gaining accepters and users of

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the wide range of currently available contraceptive technology. Thus, the performance of the programme should be assessed in part at least by the accepters it recruits and by the contraceptive protection provided. Third, performance measures must be relatively simple and readily available to administrators without requiring great amounts of time or resources for their acquisition. Measures should be available for all lower-level units and they should be available as soon as possible after the actions they measure. Programme administrators can only manage their programmes effectively if they have rapid feedback on programme performance and are able to examine the performance of relatively small action units. Finally, it is rocognized that many things beyond the control of programme administrators affect contraceptive acceptance and fertility decline. This research seeks to assess the impact on acceptance and protection of these programme characteristics that are under the control of administrators. This should enable the administrators to use their control and leadership capacities to increase the performance of their programmes. In this respect, the aims of the study are modest, but it is believed they are of great importance for what they can contribute to the larger aim of providing good service to populations and thereby helping to solve the pressing problems of population growth.

MEASUREMENT OF PROGRAMME AND CLINIC PERFORMANCE

To measure programme performance, the study uses a simple output-input ratio. Outputs are conceived as accepters, whose numbers can be weighted by the contraceptive technology they use to assess the protection gain by acce-

ptance. Inputs are conceived as personnel and time, or staff-days. Human resources are among the most important any service programme can employ. In addition, information on human resource inputs is or can easily be a normal and inexpensive part of periodic reporting. They are thus simpler and easier measures to obtain than are, for example, financial inputs. Further, staff time inputs tend to be more comparable over time and space than are financial inputs and thus provide more useful measures for administrators. Using a simple ratio of accepters per staff day (or years of protection per staff day) provides a ready measure of performance that can be used at many levels of aggregation, from the smallest unit to the total national programme, and thus can be used by administrators at many levels to assess and guide the performance of their units. There are also limitations in these measures, which will be dealt with toward the end of this report.

Two broad areas of determinants of programme productivity were identified for more detailed research. One can be identified as clinic or health centre resources. This includes both physical and human resources of individual clinics. It includes a range of indices of the quality of human resources, such as individual background and training, individual perceptions of how the family planning programme works and individual attitudes toward clients, the programme, the work group and the specific job. Second a set of instruments is used, designed by Rensis Likert in *The Human Organization* (New York, 1967), to assess the character of leadership, communication, decision making, goal setting, motivation and performance goals in the health centre as a working organization. All of these measures were obtained through interviews with health centre per-

sonnel.

Thirty-six out of the 193 Korean health centres were in the sample and altogether, 408 staff members were included interviewed for the clinic resource and organizational character data. The sample procedure involved two steps. First, urban and rural health centres were separated, since it was found that urban health centres have significantly higher productivity levels than rural centres. Within each group, health centres were ranked by productivity measures and centres were selected at roughly equal intervals to provide 26 rural and 10 urban health centres.

MEASURING PERFORMANCE: THE PRODUCTIVITY RATIO

Over-all programme development: increasing efficiency

The study first compiled data on financial and staff inputs and accepter outputs for the entire history of the national programme from 1962 to 1972. The series provided the first significant finding. ***Over the past decade, the steady increase in financial resources has produced greater human efficiency and more accepters per staff in the programme.***

For the first two years, the programme grew rapidly as a distinct organization. (figure la) Field workers increased from 183 to just over 2,000, then remained at that level for the rest of the period. Internal financial resources from the Government of Korea grew correspondingly: from 43 million won in 1962 to 150 million won in 1964. From there, the budget grew steadily to its 1972 level of about 660 million won. External financial inputs grew in the same manner, from about $275,000 in 1962 to the 1972 level of

about $4.5 million. Finally, new accepters from all methods grew with the same pattern: from 62,000 in 1962 to 288,000 in 1964, then more gradually but steadily to the 1972 level of 695,000.

When these inputs and outputs are placed in ratio form, a significant trend emerges. (figure lb) After the period of initial rapid growth, the programme became steadily more capital-absorbing and labour-saving. The cost per new accepter grew from 668 won of internal funds and $4.40 of external funds to about 1,000 won and $6.50 respectively. At the same time, the new accepters per staff grew from about 80 in 1964 to over 173 in 1972. Increasing the financial inputs of the established and well-staffed programme increased the efficiency of the programme; it brought rather large increases in returns by making the existing human resources more efficient and productive.

There is another and more dramatic way to express these ratios. In 1972, for each staff member, the family planning programme recruited about 173 new accepters. Given the current mix of methods used in the programme, each new accepter implies, on the average, about 1.75 couple years of protection. Thus, for each staff member each year, the programme achieved or produced 308 couple years of protection from fertility. It is this type of observation that has led many economists to argue that family planning programmes today represent some of the best investments Governments can make. There is another argument in these findings for increasing financial inputs. Financial resources can be considered more mobile and flexible than human resources. The latter represent more of a fixed cost, especially in government programmes where some employment security is the rule. Further, the training of a staff

member represents a sunk technological cost, which itself is relatively fixed. The Korean data indicate that these fixed costs can be made to produce significantly larger returns by the infusion of funds. The raw figures in the table 1, show that the cost in won per staff member increased 271 per cent from 1964 to 1972. (44, 000 to 163, 000) The cost per new accepter, however, increased by only 72 per cent. (550 to 945) The inflation rate during this period appears to have been in the neighbourhood of about 100 per cent, indicating that there may well have been a decrease in the real cost per accepter. This is a very rough calculation, to be sure. Nonetheless, the picture seems rather clear.

Clinic Productivity

The basic measure of programme performance is the productivity ratio. For the 13 months July 1972 through June 1973, data are available on new accepters, total accepters (new plus revisits) and staff days. These provide two measures of productivity: new accepters per staff day (NA/SD) and total accepters per staff day (TA/SD). Since different contraceptive methods provide different amounts of protection, it has become common in family planning evaluation to assess the couple years of protection provided by new or revisiting accepters of the various methods. Obviously, a sterilization accepter gives more fertility protection than does an accepter who has an IUD inserted, and this accepter in turn provides more protection than one who decider to use the oral contraceptive pill (OCP). The Korean programme has established weights for converting accepters to years of protection through detailed studies of continuation rates. The weights developed in Korea and used in the study are as follows:

		URBAN	RURAL
NEW ACCEPTERS			
	IUD	1.580	1.970
	Sterilization	12.710	12.710
	OCP	0.057	0.070
REVISITS			
	IUD	3.360	3.360
	OCP	0.057	0.070
	Condom	0.057	0.057

The couple years of protection provide two additional productivity ratios related to new or total accepters: new accepters CYP per staff day (NCYP/SD) and total accepters CYP per staff day (TCYP/SD).

Examining the relations between inputs and outputs provides the comforting results that inputs are significantly related to outputs. (See table 2) The correlation coefficients, depending on the specific measure, are 0.48 and 0.64. This is a comforting finding since it indicates that putting human resources into the family planning programme does, in fact, result in greater outputs in acceptance and protection. Since the association is quite strong, we can say that the more staff resources put into the programme, the more accepter output we obtain.

Theoretically, the four different measures of productivity, the ratios of outputs to inputs, can be considered to reflect different types of performance. Thus, new accepters reflect the capacity of the organization to recruit contraceptors. Total accepters may reflect the capacity to recruit and to sustain contraceptive activity. Either of the CYP measures may reflect the capacity of the organization to work toward long-range goals of fertility reduction rather than short-range goals of accepter recruitment, regardless of the am-

Figure 1a. Inputs (Staff and Million Won) and Outputs (New Acceptors)

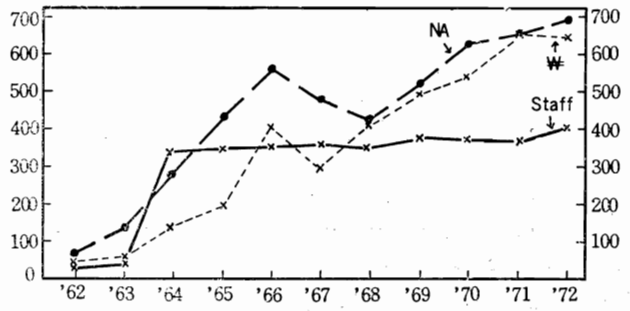
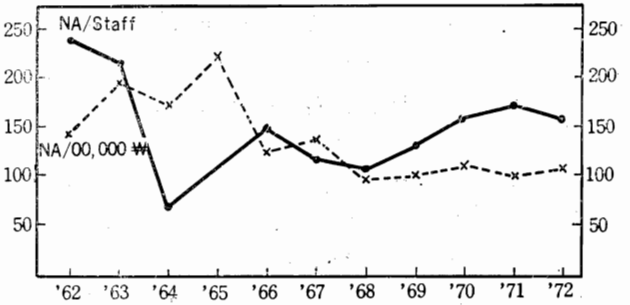


Figure 1 b. New acceptor per won and new acceptor per staff



ount of fertility protection achieved. In fact, however, the four measures are highly correlated with one another. The correlation coefficients are in the range 0.76 to 0.93. Since they are all so highly correlated, and since the total accepter CYP tends to reflect broad organizational achievement in recruiting and sustaining real fertility protection, it was decided to use the total couple years of protection per staff day (TCYP/SD) as the single measure of organizational performance.

The average for all 193 health centres on this measure is 2.09, meaning that for every staff day of input, the program gains just over 2 couple years of fertility protection. The range of measures is from 0.55 to 5.43. Thus, there is considerable variation in performance, which justified the examination of determinants of performance.

RURAL/URBAN DIFFERENCES

Higher productivity in urban areas

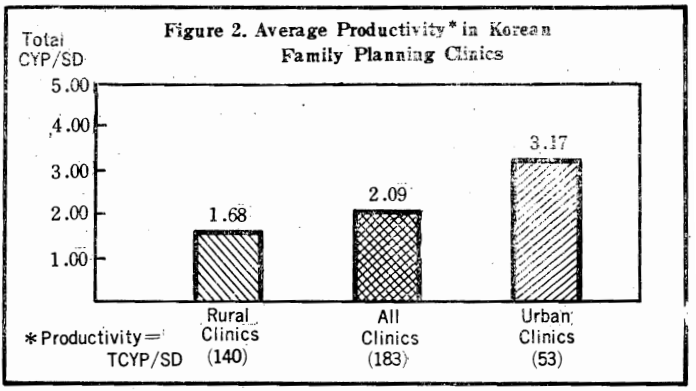
The second major finding came in the process of deciding upon the sampling procedure: ***urban health centres have higher productivity ratios than do rural health centres.***

The mean TCYP/SD for all health centres is 2.09; for the 140 rural health centres it is 1.68; and for the 53 urban health centres it is 3.17. In addition, for rural health centres, population density is correlated +0.52 with productivity, although in the urban health centres there is no relation between population density and productivity. There are two important implications of this finding.

First, urbanism and population density imply two different but complementary conditions. Urbanism is generally associated with all the characteristics we tend to call modern.

Literacy, education, personal income, industrial employment, and items of communication, such as telephones, radios and newspapers, are all present in higher rates in urban than in rural areas. All of these characteristics are in turn associated with greater acceptance of contraceptive behaviour and with lower fertility. Thus, urban areas have a larger pool of people ready and willing to engage in fertility limiting behaviour. In addition, higher population density by itself means a larger number of potential accepters in a given space, even if other characteristics were equal.

Second, it follows from this that rural and urban health centres are faced with different problems and probably require different forms of organization to deal with these problems. The urban health centre might gain a considerable number of accepters simply by opening its doors. The more modern and more densely settled population provides greater possibilities for gaining accepters by the mere fact of the availability of clinic services. The rural clinic, on the other hand, is faced with a more dispersed population, which may also be less ready to accept new contraceptive methods or fertility limitation in general. This means that, to recruit accepters, the rural health centre will have to have a greater extension capacity. Its staff will have to move out from the clinic to provide information and service sensitively geared to the needs and conditions of a more dispersed population. This, in turn, requires more technical capacity in the staff and more organizational effort to provide the incentive or motivation for the staff. It also requires logistical support, especially in the form of resources for travel. Finally, since rural areas tend to be less desirable for the more trained and experienced staff, rural clinics may require additional incentives to recruit the quality of



staff required to provide full services.

We shall point out below some of the more distinctive characteristics that seem to be required in rural clinics, but here we wish to emphasize the fact of the difference itself. Few family planning programmes appear to be aware of this difference or to take it into consideration in planning activities and allocating resources. The common pattern is for family planning programmes to create standard clinic units to deal with all types of situations. The Korean findings suggest that it would be most useful to give some consideration to establishing different types of clinics in rural and in urban areas.

Clinic resources

The physical resources of the health centres — medical equipment, waiting room space, total space, etc. — were not related to productivity. It appears that the Korean programme is well established physically, and whatever material conditions do obtain in the clinics do not affect the level of performance.

The human resources, or staffing pattern of the clinic,

however, are significantly related to productivity. For both urban and rural clinics, the number of doctors and nurse/midwives in the clinic is related to productivity. In addition, the number of designated doctors is significantly higher for high productivity clinics than for low productivity clinics. (The Korean programme uses private doctors, designated by Government, to provide services in IUD insertion and sterilization. Clinic personnel refer accepters to these doctors, who are then paid a fee for service by the Government). *This would indicate that an over-all upgrading of the staff, providing for more doctors and nurse/midwives, and designating more doctors from the private sector, could be expected to increase the output of both rural and urban health centres.*

There is an additional important difference to be considered between urban and rural health centres in the staffing pattern. The average number of health assistants, the less trained paramedical personnel, who are used chiefly for field motivational work, is positively related to productivity, but only in urban health centres. In rural health centres, the average number of health assistants is almost the same for high and low productivity clinics. (figure 4) Further, when we consider the number of health assistants as a proportion of total clinic staff, we find a negative association with productivity in the rural areas, and no association in the urban areas. That is to say, in the urban areas, the simple addition of less trained health assistants, supervised by more qualified people already available, can be expected to increase output. *In the rural areas, the addition of less trained health assistants cannot be expected to increase output unless more highly trained staff are also added for their supervision.*

There are additional rural-urban differences in staff background characteristics that help to complete the picture of how human resources are related to clinic performance in rural and urban clinics. For urban clinics, the number of children (male or total) of the staff and the extent to which staff report "knowing well" the clients are negatively associated with productivity. For the rural clinics, these variables are unrelated to productivity, but other background characteristics are important. Age over 30, longer family planning experience, practising contraception and having had some family planning training are personal characteristics significantly correlated with clinic productivity. These characteristics are all related to staff position, as the less trained health assistants tend to be younger, to have less work experience in family planning and fewer children, and tend less to practise contraception.

There emerges an interesting and intuitively acceptable picture of the staffing requirements in urban and rural clinics. Urban clinics are already staffed with the basic requirements of doctors and nurse/midwives, who can effectively supervise and guide less trained staff. Further, in the urban areas, the younger, less socially encumbered staff (with fewer children and fewer neighbourhood connections) can apparently move about in the work of motivation quite effectively. The greater impersonality of the urban setting does not require more stable staff whose own personal reproduction lives are known and are necessary models for potential accepters. In the rural areas, where staff tend to be known as persons, maturity, work experience and the personal reproductive experience of the staff serve as characteristics that certify the motivator as credible to the potential clients.

Figure 3. Average Number of Staff in High and Low Productivity Urban and Rural Clinics

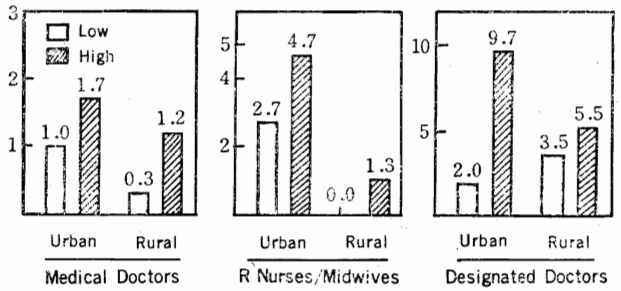
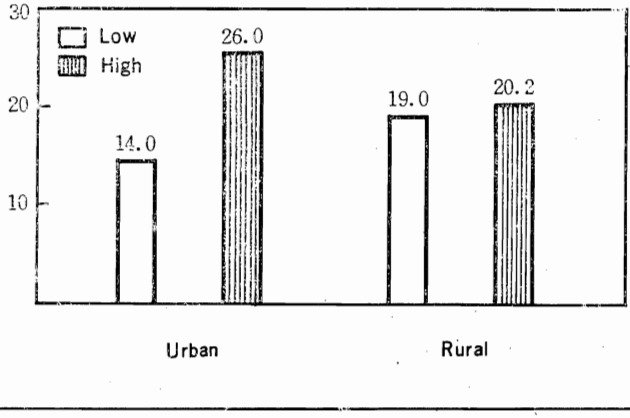


Figure 4. Average Number of Health Assistants Per Clinic



Thus, the suggestion to upgrade staff in order to increase output can be made somewhat more direct and precise. *The upgrading of staff in the rural clinics and a simple increase of less trained staff in the urban area s could be expected to increase over-all output.* In part, of course, this suggestion rests on the assumption that the higher quality of the urban staff provides a sufficient supervisory base on which additional less trained staff can be built. It would be useful, in any personnel programme aimed simply at increasing less trained staff, to monitor the returns to determine the point at which diminishing returns begin. This would be the point of optimum staffing for effective supervision.

Clinic personnel: perceptions of organizational processes

In individual interviews with over 400 clinic staff, questions were posed on staff capacities for communication with patients, technical and educational background, the way the staff viewed such things as the flow of funds and supplies, and staff attitudes toward their work, the family planning programme and their clients. Three distinctive groups of conditions or personnel responses can be identified, which are significant correlated with clinic productivity. Most of these are same for rural and urban clinics and only two are different. (The analysis used simple correlation coefficients to investigate the relation between productivity and a wide range of characteristics. Table 5 shows the most important coefficients).

For all clinics, *staff perceptions of logistical problems, interagency contact and staff attitudes* are significantly associated with productivity. First, the reporting of shortages or delays in contraceptive supplies and in the payment of

salaries and bonuses is related to productivity. The less these logistical problems reported the higher the productivity. Second, the more the staff report a high amount of contact with and support from other agencies of government, the higher the productivity. Finally, the more positive the staff attitudes are toward the clients, their own work groups, the family planning programme and their own jobs, the higher the productivity. These three sets of characteristics are also interrelated. That is, less reporting of logistical problems is related with reporting of higher interagency contact and support and with more positive staff attitudes. Delay in payment of travel allowances was not related to productivity in urban clinics, but it was significantly related to productivity in rural clinics. Apparently, where travel is more necessary, among the more dispersed population of the rural areas, delays in travel payments to field staff reduce the productivity of the local unit.

It was not possible to probe deeply into the causes of logistical problems, contacts with other agencies or staff attitudes. It would be most useful to investigate these issues more fully. It is possible, however, to suggest a theory or set of explanations that is consistent with findings and also with a very extensive literature on management procedures and performance. The data suggest that specific managerial problems can be identified in the local health centres and in their immediate administrative environments. Since the problems identified here vary to the extent to which clinics experience them, and since that extent is related to clinic performance, it is justifiable to locate the managerial problem at the local level. It is a nomal part of any managerial or administrative task to ensure a proper supply of the resources needed and to supervise personnel in such a

way as to keep morale and output high. When delays and shortages are reported, there may well be a problem in the schedule of requisiton or inventory maintenance or reporting. When staff attitudes are negative, we may well have problems insupervisory styles. It appears that some attention given to these problems at the lecal lovel might well increase output.

The local clinics do not operate in a vacuum, however. They depend upon higher levels, in both the Ministry of Health and Social Affairs and in the civil adminstrative structure, for the flow of supplies and funds. Funds flowing from the general administrative structure must pass through provincial and county offices to be disbursed to the local fieldworkers. If relations with these lower levels are not smooth or if the leadership in these levels is not fully supportive of the family planning programme, resistance and delays in resource allocation can be expected. What determines the character of the relations between the clinic and the county and provincial governments is not at all clear. It may be a result of the leadership and administrative skills of the health centre director, the skills and interest of the county chief or provincial governor, or some interaction between these.

One specific difference between rural and urban clinics sheds some light on this problem, indicating how the relation between the clinic and the local administrative offices in rural areas is a crucial determinant of productivity. Clinic staff were asked how much work outside of family planning they were required to do by the township or county chief during both busy and slack agricultural seasons. It is not uncommon, especially in the rural areas, for township chiefs to enlist the time and effort of family planning personnel

in special tasks that are assigned to them by their own superiors. *In urban areas, the amount of this extra work is negatively related to clinic productivity. That is, time taken away from family planning reduces output and productivity. In the rural areas, on the other hand, time taken out of family planning for other tasks is positively related to productivity. Doing additional work for the township chief increases clinic output and productivity.*

Further, in the rural areas, the amount of time taken out of family planning is positively related to the perceived support of other agencies; in urban areas, the relationship is negative. Time taken from family planning in the rural areas is also negatively related to perceived delays in the rural areas is also negatively related to perceived delays in supplies and payments. Thus, in the rural areas, giving staff time for non-family planning activities appears to lead to good relations with local administrative officials, which facilitates the flow of resources and assists the family planning programme itself. It is also probable that, in rural areas, giving time for other activities produces a reciprocal reaction, in which other officers in turn give assistance to family planning.

The whole picture in the rural areas in one in which co-operation among various agencies and offices produces a cohesive team approach to family planning and increases the productivity of the individual clinics. In the urban areas on the other hand, the greater impersonality apparently also means that individual technical agencies can operate relatively effectively on their own. Co-operation with other agencies does not necessarily produce either reciprocal assistance for family planning or the advantages of a more cohesive team approach, with its advantages for family

planning as well as for other activities.

One final observation is worth making. As noted above, in rural areas, the proportion of total staff who were health assistants, an indication of lower quality of less training of staff, was negatively as sociated with productivity; lower training or quality means lower productivity. Further, among rural clinics, a higher proportion of health assistants is associated with less perceived support from other agencies and less reported extra work outside of family planning.

Over-all, then, it is possible to identify specific managerial or administrative problems that seem to reduce productivity. For all clinics, these are problems of supply and the flow of funds and support from other agencies. Attention and efforts to smoothing the flow of funds and supplies can be expected to increase the productivity of the existing system.

Whatever administrative or managerial problems exist over-all are amplified in the rural clinics, and additional specific problems are laid upon them. Rural clinics are less well staffed with doctors and nurse/midwives; a higher proportion of their staff assists of the less trained and less experienced health assistants. This in itself probably constitutes an impediment to motivation and recruitment, but it also constitutes a special set of managerial problems as well. There appears to be a syndrome of weak leadership affecting productivity in the less well staffed clinics. Weak leadership also means poor relations with local administrative officials, less contact with them, less non-family planning work done for them, and more delays in funds and supplies. Thus, the problems that should receive attention in the rural clinics include both the upgrading of staff and improvement of relations with local civil administrators. Improving relations implies greater co-opera-

tion given by family planning to local administrator. For in this case, time taken off from family planning work by family planning staff appears to help the programme rather than to hinder it.

Organizational profiles

The attempt to assess organizational characteristics was less successful and still requires much work to refine the instruments for measurement. There is less confidence in the findings here, partly because of the small size of the sample. Nonetheless, some results consistent with other findings merit some confidence. The quality of communication and decision making, assessed by clinic workers, was associated with productivity. Here, the quality of communication means the amout of both upward and downward communication, the accuracy of the information that flows, and the degree to which superiors share all forms of information with subordinates. The quality of decision-making means the extent to which subordinates are actively drawn into discussions over what the organizations should do and how it should be done.

In the early phases of our research, there was some concern that the values underlying the organizational theories on which the research was based assumed a democratic administrative culture. It was observed that the basic administrative culture of the Republic of Korea is more authoritarian and that workers fell more comfortable with and perform better under stronger and more authoritarian leadership. The data suggest that this may not be the case. The problem may lie in part, however, in the confusion of strong with authoritarian leadership. Leadership can be strong and forceful without precluding participation by

workers in the communication and decision-making processes. The data workers in the communication and decision-making processes. The data suggest that the Korean leaders who do indeed support and encourage active and accurate communication within the health centre, and who use general staff discussions to make decisions upon courses of action for the clinic also thereby produce more output per worker.

FINAL CONSIDERATIONS AND LIMITATIONS

This research project demonstrates that it is possible to assess family planning clinic performance in the Korean setting with simple and readily available measures. The productivity ratio, accepters or couple years of protection per staff day, is shown to provide a useful, valid and economic tool for assessing performance. It provides for the identification of conditions that reduce the over-all efficiency of the programme and suggests plausible courses of action that might be expected to increase performance.

This strategy will not solve all or perhaps even a majority of the problems the programme faces. Many of these lie outside the direct control of the programme administrators. But the administrators do control a large and well established distribution and service system. The research does identify some of the things which can be done directly by the administrators and which have a good chance of increasing the output of the existing system without greatly increasing the cost.

A word of caution is in order, however, especially over the use of the productivity ratio. Administrators can use this ratio, and it can be used at many operating levels for

supervisors to assess and guide the performance of their own units. Nevertheless, the utility or effectiveness of even the best measure of performance will depend largely on how it is used. Many family planning programmes have discovered that simply laying down targets of accepters for local units results in great success in targets, achievement. All too often, however, that success is more in the reporting than in the actual field-work. If administrators insist upon local units meeting targets, and distribute rewards and punishments on the basis of target achievement, local units will find some way of reporting the achievement of targets. The productivity ratio is as subject to this kind of subversion as any other measure. If local units are pressed from above to achieve high ratios, they can easily deflate the input measure by counting all staff absences (even those of only a few moments duration) and thereby reduce the input value of the ratio. They can also inflate accepter numbers, especially if free or low-cost pills and condoms are part of the method distributed.

That is to say, the productivity ratios can be used effectively as measures of performance, but only if they are used primarily as self-guidance and assistance-generating instruments rather than as punitive instruments. First, supervisors at all levels can be asked to record inputs and outputs and to compute their own productivity ratios on a month-to-month basis. They can be asked to use their own past experiences as standards against which to assess current performance. Upper-level administrators can use productivity ratios to signal problem areas in which some assistance is required. For example, in Korea, declining productivity ratios may well mean that upper levels of management need to help free resources so that staff receive pay and

travel allowances on time, or that the local unit needs help in smoothing relations with local civil administrators. If local supervisors can look to the upper levels for assistance in times of need, they are more likely to record and report their performance accurately and to use the productivity ratio to improve their performance.

Upper-level administrators and programme directors in turn can use the productivity ratios to present reasonable agruments for more resources or more assistance. For example, the Korean programme is a large and well-established programme. It already has large recurrent costs that cannot easily be reduced. The returns to those fixed costs can vary considerably, however, depanding upon small additional resources or merely freeing allocated resources for more timely distribution.

As a whole, the productivity ratio can provide a useful measure of programme performance. But it will be more accurate and more useful to the extent that it is used as a sensitive instrument for improving performance rather than as a heavy club for punishing poor performance.

Finally, the applicability of the Korean experience to other family planning programmes should be assessed. It should be noted that the Korean programm is a well-established and very experienced programme, with considerable resources and support from the Government. It operates in a country with a high population density and high levels of general social and economic modernization. These may be the optimum conditions for the development and application of tools which enable programme administrators and supervisors to assess and improve the performance of the organizational units over which they have control. Where environmental conditions are less favourable or res-

ource allocations less secure, the amount of programme improvement to be gained through increasing unit efficiency may be quite small. Nonetheless, it is considered useful for all programmes to assess their performance systematically and to relate performance to some form of resource input. This is a simple strategy, but it is probably one of the more important elements in the thrust toward improving the amount and quality of services provided to population very much in need of assistance.

Table 1. General Programme Inputs, Outputs and Ratios, Republic of Korea 1962~1972

Year	New[a] accepters (thousands)	MOHSA Staff	NA/Staff	Workers	NA/FW
1962	62	255	243.1	183	338.8
1963	151	704	214.5	366	412.6
1964	288	3,592	80.2	2,062	139.7
1965	431	3,669	117.5	2,076	207.6
1966	580	3,701	156.7	2,125	272.9
1967	495	3,909	126.6	2,202	224.8
1968	440	3,774	116.6	2,067	212.9
1969	539	3,884	138.8	2,098	256.9
1970	646	3,814	169.4	2,236	288.9
1971	674	3,791	177.8	2,068	325.9
1972	695	4,020	172.9	2,238	310.5
Total	5,001	35,113	1,714.1	19,721	2,991.5
(Mean)	(454.6)	(3,192.1)	(155.8)	(1,792.8)	(272.0)

a: simple summation of each method

Table 1. General Programme Inputs, Outputs and Ratios, Republic of Korea 1962~1972 (cont'd)

Year	Expenditure[b] (million won)	W/NA	Total $ US[c] (thousands)	$ US/NA
1962	42.7*	668.8	275	4.4355
1963	77.0*	509.9	405	2.6821
1964	158.2	549.3	1,098	3.8125
1965	195.4	453.4	1,302	3.0209
1966	423.1	729.5	2,318	3.9966
1967	324.9	656.4	2,582	5.2162
1968	430.0	977.3	4,310	9.7955
1969	512.7	951.2	4,726	8.7681
1970	561.4	869.0	4,470	6.9195
1971	674.4	1000.6	5,665	8.4050
1972	657.0	945.3	4,488	6.4576
Total	4056.8	8330.6	31,639	63.5095
(Mean)	(368.8)	(757.3)	(2,876.3)	(5.7736)

b & c: source from USAID booklet, 1973. p. 14.

*: These two amounts of actual expenditure are estimated based on the expenditure ratio for the succeeding nine years: 97.82 per cent.

Table 2. Correlation Co-efficients of Inputs-Outputs and Productivity (193 Clinics)

	SD	NA	TA	NA/SD	TA/SD	NCYP/SD	TCYP/SD
SD	1.00						
NA	0.48	1.00					
TA	0.64	0.88	1.00				
NA/SD	0.16	0.71	0.52	1.00			
TA/SD	0.35	0.37	0.42	0.76	1.00		
NCYP/SD	0.22	0.56	0.49	0.86	0.84	1.00	
TCYP/SD	0.28	0.49	0.46	0.83	0.89	0.98	1.00

All values are significant at .05 level, except that between SD and NA/SD.

Table 3. Levels of Programme Productivity (TCYP/SD) for all Urban and Rural Health Centres

Health centres	N	Mean TCYP/SD	Range	Number of health center's in each quartile I (low)	II	III	IV (high)
Urban	53	3.17	1.33~5.43	3	4	7	39
Rural	140	1.68	0.55~3.48	46	44	41	9
Total	193	2.09	0.55~5.43	49	48	48	48

Table 4. Average Number of Occupational Personnel in Higher and Lower Productive Clinics of Urban and Rural Areas*

	Urban			Rural		
	Total (10)	High (3)	Low (3)	Total (26)	High (6)	Low (6)
MD's	1.20	1.67	1.00	1.46	1.17	0.33
Nurses/midwives	2.7	4.67	2.67	1.31	1.33	0.0
Nurses	4.3	6.33	4.33	2.38	2.7	2.67
Midwives	0.3	0.0	1.0	0.42	0.67	0.0
Health assistant	10.9	26.00	14.00	11.40	20.33	19.00
Designated doctors	4.0	9.67	2.0	5.58	5.50	3.50

* Averages only for the highest and lowest three among urban clinics and the highest and lowest six among the rural clinics have been shown.

Table 5. Zero-Order Correlation Co-Efficients between Clinic Productivity and Other Variables in Rural and Urban Clinics* (Only important co-efficients are shown)

	Rural	Urban
Proportion health assistants of total clinic staff	+0.39	—
Proportion of clinic staff over 30	−0.33	—
Proportion having no or one child	—	+0.80
Proportions who have ever practised contraception	+0.40	—
Proportions who have had no FP training	−0.40	—
Percentage well acquainted with people in clinic area	—	−0.32
Proportion reporting frequent shortages in		
Contraceptive supplies	−0.37	−0.28
Salary payments	−0.45	−0.47
Bonus payments	−0.40	−0.38
Travel payments	−0.28	—
Proportion reporting frequent delays in		
Contraceptive supplies	−0.38	−0.31
Salary payments	−0.48	−0.42
Travel payments	−0.23	—
Bonus payments	−0.41	−0.37
Proportion reporting much contact with other local agencies	+0.60	+0.50
Proportion reporting high support from other agencies	+0.58	+0.51
Proportion reporting much extra work in non-family planning	+0.29	−0.35
Attitudes towards**		
Clients/accepters	+0.37	+0.31
The clinic work group	+0.44	+0.42
The family planning programme	+0.47	+0.43
The immediate job	+0.38	+0.41

* Number of rural clinics=26; number of urban clinics=10.
** Attitudes are scored from high (positive) to low (negative).

PART III

CASE STUDY

Kim, Mong Sool*

CHAPTER 7

Unclarified Tasks in a Health Center

Task Clarification Case

One day in late autumn, when the weight of the golden stalks of rice promised an abundant harvest, the County Health Center located in an estern county in Gangweon province, 300 kilometers from the capital city of Seoul, was crowded with staff members, patients and other visitors.

THE PERFORMANCE TARGET PROBLEMS

The Health Center Director, a medical doctor, was responsible for providing medical services to the patients in addition to allocating the family planning targets assigned by the central government and general administrative duties involved with the day to day functioning of the health center. As he worked at his desk, Dr. Park thought about senior worker, Nurse Kim who was already over burdened with work; and knew that additional pressure would no

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improve anything. His mind then turned to the deterioration of the working relations among the center personnel and considered the possibility of trying to improve them. A first step, possibly, would be to reassess job descriptions and work assignments.

Meantime, in the Family Planning Room on the second floor of the Health Center, a room of about 23 square meters, the senior worker, Nurse Kim, was absorbed in a phone conversation which had already lasted for more than an hour; raising her voice now and then as she confirmed the month's contraceptive targets and achievements. She asked particularly about those fieldworkers who had not achieved their targets; requesting an explanation for the poor results.

Behind Nurse Kim, a large blackboard on the wall listed the monthly and quarterly primary and supplementary targets and achievements for each method available through the Health Center; IUD, oral pill, and condom, as well as male and female sterilization. As of mid-October, the primary target for each method in 1976 which was originally given to the Health Center early that year, had been achieved. Thus, additional supplementary targets had been assigned for the remainder of the year. However, because of the individual characteristics of the different localities served by the various Health Centers scattered over the nation, some methods were less well accepted than others; which meant that target achievement for some methods was very difficult in various parts of the country. The fieldworkers frequently complained about the unrealistic targets for those methods not well received in their areas. When one fieldworker in the Health Center's area cannot achieve her targets, the targets are reassigned to the other

fieldworkers in that same area served by that particular Health Center.

If the Health Center ranks lower than tenth of all the 19 Health Centers in Gangweon province, there is a great deal of pressure and criticism to improve the overall performance. — *Target Setting System**

HEALTH CENTER MILIEU

Judging from project results, this Health Center is about average compared to all 198 such health centers scattered across the nation. There are 14 staff members including the director who is a physician. The total population served by this particular health center numbers 74,151; including

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* Each year the central government determines the national contraceptive user target for that year. This total target is determined at a level to be consistent with the national population and econo mic growth rates; as well as general social development considerations. The total targets are sub-divided into a county level, and each of the 198 county health centers (one per country) is responsible for achieving their assigned target. The target for each county is once more sub-divided by method; including the oral pill, IUD, condom, female sterilization. In other words, a certain member of acceptors for each method must be recruited. Unfortunately, this target-by-method system tends to ignore individual characteristics and preferences in the different areas. Also, because the fieldworkers are pressured to achieve a certain number of acceptors for each method, it often leads to the following two major problems; (1) pressuring couples into accepting one particular method when they would prefer another which in turn contributes to a high drop-out rate and incorrect use, and (2) false reporting by the fieldworkers whose jobs are threatened by underachievement.

38,124 men and 36,027 women representing 13,861 households. Among the total female population, 9,700 are married eligible women; the primary family planning audience. The population is scattered across 743.23km^3 with a density of 99.8 people per square kilometer. Most of the population depends on farming for a living; although the mountainous terrain interferes with productivity and the resulting standard of living. The population in general is very mobile, which is a problem in conducting successful health projects.

The primary activities of the Health Center, like all the other health centers, can be divided into four major areas: (1) health administration and education, (2) communicable disease prevention and control, (3) environmental health, and (4) family planning including maternal and child health. It should also be remembered that the health center personnel are frequently required to participate in various New Village Movement activities: a govenment sponsored self-help development program. The health center officials frequently complain that such community requirements interfere with their health work. According to the county chief's own personal opinion, the family planning program receives just an average priority among all the various community programs and activities.

The primary activity of the health center's population program is to supply contraceptive methods recommended by the government at no charge, or only a nominal charge. Pills and condoms, as well as complete family planning information, are supplied via the health center and the local Mother's Clubs. The IUD and both male and female sterilization, which require close medical supervision, are performed at the closest government designated hospital

or clinic.

The most recent change in the national family planning program is that the government has decided to integrate it with the New Village Movement. Accordingly, new slogans and terms such as, "family planning is basic to a good life," and "family planning must suit individual needs" are frequently heard.

In addition to the government supply source, those who wish to can always obtain the same contraceptive supplies and services from the commercial sector via pharmacies, clinics, and hospitals.

DUTIES OF THE SENIOR WORKERS

The senior worker Nurse Kim, seated at the end of the long brown meeting table, is still single although now well into her fifties. Rather short and somewhat dark complected, round-faced Nurse Kim is introspective, and lacks the ability to compromise and adapt; although she is of unquestionable character and honesty.

Nurse Kim, with both a nurse and midwife licence, has more clinical experience than administrative experience. She has been a head nurse at various distinguished provincial hospitals, and was appointed as a senior worker last November by a decree of the Ministry of Health and Social Affairs (MOHSA). This is part of the effort of the MOHSA to place competent nurses on the health center staffs rather than less well trained personnel. The former senior worker, Ms. Han, who has a nurse license and ten years experience in the population field, was forced to resign her post, and appointed to a lower rank; assistant to the new senior worker.

The forty year old, energetic and even-tempered health

center worker, Ms. Han, was a typical veteran of the population field; having competently conducted duties of the senior worker position before her demotion. She is a skilled administrator and maintained good working relationships with the outside community.

The reason why senior worker Nurse Kim is busy confirming the monthly achievement figures by phone is that she has often been reprimanded by the sub-section chief Mr. Lee for the low target achievements which have steadily decreased since she assumed the senior worker post. Because of the decreasing achievement levels, the sub-section chief Mr. Lee or the health center director Dr. Park have frequently requested to higher authorities that the targets be lowered to be more consistent with the achievements. Nurse Kim is greatly embarrassed by the poor showing and feels personally responsible. Because of the poor results, Nurse Kim frequently considers returning to her former hospital based job where she always performed her duties with a high degree of competence. Another problem has arisen because the sub-section chief is embarrassed to go to the county chief's office every month for his official signature on the target achievement forms because of the poor results in recent months. Mr. Lee has now asked Nurse Kim to assume that duty.

Nurse Kim is not used to the problems involved with an administrative job, particularly the time consuming process of getting official signatures on various documents every day. Daily she must go through that official process five or six times. To complicate this matter, she has found it difficult to obtain the necessary approval and signature from the sub-section chief Mr. Lee because he was appointed to the job only six months before with no previous po-

pulation, much less health program, experience. He has transferred jobs three times in the past two years. The sub-section chief, however, considers himself an expert administrator and is frequently dissatisfied with Nurse Kim's administrative procedures. In part, this feeling arises from the usual attitude on the part of administrators that technicians cannot also be administrators.

Although patient counseling is assigned to other health center workers, the more complicated cases must be seen by Nurse Kim. She is continually interrupted in her administrative tasks to consult with patients.

Nurse Kim must also draw up monthly statistics and reports; including the number of new and discontinued acceptors and the member of pill users. She must also keep books for the nominal pill fees which are collected, and send the statistical coupons to the national statistical office in Seoul.

Many of these tasks could be assigned to one of the workers on her staff; but Nurse Kim is typical in thinking only she is capable of doing the more important tasks and is therefore very reluctant to assign them to others.

In order to perform these numerous duties, the need for excellent training and skills on the part of the senior worker is obvious. she should have excellent administration techniques, medical techniques, IE & C techniques including the ability to conduct rumor control and health education programs for various community groups, and supply management techniques.

Because of the extensive array of duties and obligations with her job, it is easy to see why many of the duties are inadequately performed, even if capable assistants are available.

In addition, Nurse Kim must devise and confirm field-worker schedules every afternoon. She must also conduct petty, more annoying duties such as making sure patient signatures are in the client's records when she receives contraceptive supplies, and filing client records. Most senior workers want someone else to conduct such duties. Senior workers are also required to assign and reassign contraceptive targets, conduct population education programs in the schools, attend various public meetings on population such as the Mothers' Clubs, insert IUD's and conduct IE & C the Planned Parenthood branch office and the provincial activities with mobile van team, treat side effects, and inspect and supervise all IUD and sterilization facilities.

COOPERATION VIA PROPER JOB ALLOCATION

The former senior health center worker, Ms. Han, was forced to resign her position after ten years experience because she was only licensed as a nurse aide rather than a nurse. She of course feels embarrassed and offended at having to give up her job to Nurse Kim and accept a demotion. She is not willing to assist Nurse Kim in learning her new job as senior worker: even when Nurse Kim makes obvious mistakes. Because the new senior worker cannot adequately perform her administrative duties and is often reprimanded by the sub-section chief and because the former senior worker refuses to assist her, the personal relationships between these two workers is very poor.

Other health center workers are not assigned such heavy work loads and they frequently have a great deal of spare time. Occassionally they take field trips to encourage field workers and counsel patients, as well as occassionally help

write the monthly statistical reports. However, this extra assistance to the senior worker is unpredictable and sporadic as it is not a regular part of the workers job description. Since the former senior worker was forced to resign her position, inter-staff cooperation has decreased and support for the fieldworkers from the health center staff has likewise decreased. The health center director and sub-section chief have done nothing to stop or reverse this trend. The director and sub-section chief do not themselves actively support the fieldworkers; but limit themselves to checking monthly target achievements.

The sub-section chief, according to the health center regulations and job description, has two distinct jobs; to conduct all administrative duties within the health center, and act as the general director of the family planning program.

The sub-section chief, Mr. Lee, in his early forties, is an administrative authority with 15 years experience in various county offices. He has never worked in the health field before, and still does not clearly understand the area. He complains that supervising women is more troublesome than men: and that many of the health center activities now done by administrators should be done by doctors and other health personnel. His duties in the family planning project consist primarily of supervising general document procedures, budget management, and personnel administration. He also supports administrative affairs in cooperation with volunteer and other outside agencies.

RELATIONSHIPS BETWEEN ADMINISTRATIVE AND TECHNICAL PERSONNEL

Frequently, health center personnel differ in their opinions on how to handle contraceptive target readjustments. For example, when the supplementary target was assigned, the health center director and senior worker both believed male and female sterilizations supplementary targets should be based on the primary targets originally assigned that year. However, the sub-section chief and former senior worker both believed the targets should be drastically revised. Eventually the two groups compromised and reached an agreement; but not before personal antagonism greatly increased.

At one point the health center director said that most matters concerned with the family planning project should be decided by the senior worker, a nurse. However, he said the hospital based family planning program and the health center should share contraceptive targets; while the senior worker objected and said they should be clearly separate. Eventually, the director followed his own opinion on the matter. At that time, the sub-section chief and former senior worker declared their opinion that the director was correct; the current senior worker wrong.

The director believes that the administrative staff know very little about the family planning project and he often disturbs and upsets the usual order of administration. For example if he does not trust certain information or opinions of the sub-section chief; he goes to the senior worker for information. Of course the sub-section chief is embarrassed, somewhat humiliated, that the director goes to his sub-

ordinate for confirmation of information. The sub-section chief in turn embarrasses the senior worker by altering her scheduling of the fieldworker's time on the basis of what the field workers, not the senior worker, say is needed.

Another source of antagonism developed when the senior worker requested vehicles and male assistance to conduct vasectomy IE & C and service programs for the reserve army; and the sub-section chief who supposedly had many contacts in the county office became involved and only poor results were achieved. To the further embarrassment of the senior worker, the sub-section chief altered her plan for the fieldworker's rotation, without her advise or consent.

A further source of conflict is the community projects with which health center personnel are forced to assist; but which interfere with their family planning achievement. The senior worker says it is only fair to exclude staff in those areas where target achievement is especially difficult from the community development projects; but the sub-section chief says they must participate and still achieve their family planning targets.

APPLICATION OF MANAGEMENT TECHNIQUES TO PLANNING AND EVALUATION

The most important role of the health center director, sub-section chief and senior worker is to plan and evaluate the health center activities, and utilize scientific management techiques to insure effective achievement of program goals. By applying these basic principles as well as proper job assignment, better program performance can be logically expected.

The senior worker Nurse Kim has the difficult job of

preparing the target achievement reports and determining the reasons for low performance. She holds a monthly meeting with the fieldworkers and the health center director and sub-section chief. Of all the fieldworkers for 17 townships covered by the health center, only two townships had a reasonable achievement level. Those two workers received a great deal of praise during the meeting and the others were reprimanded. The sub-section chief Mr. Lee was especially harsh in his criticism and said to the low achievers if they, "did not achieve the targets by the end of the year, they could submit their resignation". The field workers were ashamed and embarrassed; but at the same time said the male and female sterilization targets were unrealistically high. However, the sub-section chief Mr. Lee insisted the targets could be reached as had already been demonstrated in other areas.

Special IE & C sterilization strategies were then discussed for the under achieving areas but plans were cancelled due to logistical problems of mobilizing vehicles.

It should be noted that even though the senior workers prepare the monthly reports based on the coupons, they are not utilized at the time of target determination and allotment. Also the target achievement reports of acceptors and discontinuers by method are not utilized during the target setting, or discussions sessions of new ideas and approaches to best increase acceptor numbers, even though the senior worker makes most of the decisions concerning the targets and possible new approaches. It seems the senior worker just does not know how to use the monthly reports she prepares for rational planning. She occassionally goes to the health center director and the sub-section chief for assistance in target setting, but neither person knows how to utilize her

monthly data for target setting any more than she does.

The director, however, has very adequately performed his clinical duties with the patients.

When the health center did not have a director last year, the senior worker had to spend a great deal of time consulting local doctors in the community.

PRINCIPAL DUTIES OF HEALTH CENTER FAMILY PLANNING PROGRAM STAFF

HEALTH CENTER DIRECTOR

1. *Direct and supervise health center projects*
2. *Conduct project planning*
3. *Periodically check project progress*
4. *Supervise staff*
   a. *Appoint staff members*
   b. *Assess staff activities*
   c. *Determine and assign staff duties*

SUB-SECTION CHIEF

1. *Conduct Administrative duties of all health center projects*
2. *Conduct program planning and evaluation*
3. *Conduct Budget planning and control*
4. *Direct and supervise all medical facilities performing family planning services in the county*
5. *Manage budget for physician incentive payments*
6. *Direct and supervise staff activities*
7. *Assess personnel administration for staff*

SENIOR WORKER

1. *Assign and adjust family planning targets and field worker activities*
2. *Prepare monthly statistical reports*
3. *Assess and supervise medical facilities which provide family planning services*
4. *Insert IUD and treat contraceptive side effects*
5. *Conduct administrative duties concerning family planning program*
6. *Write monthly activity reports*
7. *Train new staff members*
8. *Establish project plan and collect data for project plan analysis*
9. *Collect data on population, fecund women, acceptors of mothers' clubs, and other organizations*
10. *Conduct education for local defense reserve forces and mothers' clubs*
11. *Attend various meetings concerning population program*
12. *Conduct monthly meetings with field workers*
13. *Direct management of mothers' clubs*
14. *Supervise epidemic prevention project, including preventive inoculation*
15. *Support New Village Movements project*

HEALTH CENTER WORKER

1. *Conduct fieldwoker duties; house visiting*
2. *Encourage field workers through official field trips more than 20 days a month to the areas where field-*

workers are working

3. *Assess situation of project and problems of Eup and Myon*
4. *Counsel patients and supply contraceptives*
5. *Conduct administrative duties*

Han, Dae Woo M.D., Dr. P.H.

CHAPTER 8

Leadership Behavior and Family Planning Program Performance

Leadership Case

Health center A has been rated twenty-seventh out of 198 health centers across the country in terms of achievement in recruiting family planning acceptors. According to reports filed by the center to the Korean Institute for Family Planning covering the period from July 1975 through June 1976, there are 25.7 acceptors per every 100 eligible women in the county. (See Appendix 1) This health center, under the leadership of a health center director, is composed of a health administration, quarantine sub-section, and medical-pharmaceutical sub-section. (See Appendix 2) The family planning program is the responsibility of the health administration subsection which operates a family planning counselling center. This sub-section sends out family planning field workers to each Myon, and they are assigned to recruit eligible women in villages for family planning in cooperation with village Mothers' Club members.

Another health center named H had a low achievement

level of only 11.2 acceptors per 100 eligible women. The center is rated 151st of the 198 health center in terms of achievement ranking. It is interesting to note, however, that this unsuccessful health center has almost an identical organizational structure and family planning delivery system. In addition, the socio-economic characteristics of both counties are also almost identical.

CASE OF HEALTH CENTER A

One afternoon in late fall during several days of cold, crisp weather, Dr. Kim, health center director, and Miss Park, senior family planning worker, were talking to each other in the health center office. Shortly before her arrival in the office, this senior family planning worker received a report of a vasectomy patient's side effects after having the surgery at a designated clinic located in township A. This report was filed by a family planning field worker assigned to township C during a phone conversation with the senior worker, Miss Park. Upon hearing this news, the senior worker immediately reported it to the health center director and discussed possible solutions to the problem. In addition to discussing treatment for the patient, they also discussed ways to avoid the spread of negative rumors concerning vasectomy.

GENERAL STATUS OF HEALTH CENTER A

This county, a typical mountainous area located at the northern most tip of province K, had a total population of 114,346 (58,239 men and 56,107 women) as of the end of October 1975. There were 19,554 households with 16,214

eligible women.

Although a majority of the population in this county (13,522) reported farming as their occupation, this county is surrounded by rugged terrain, more rugged than any other county in this province. As compared with the national average rural income, inhabitants of this county have a slightly lower income level. Even though county A is located in a mountainous area, it shares a boundary with county S which contains many mineral resources. In order to utilize these vast reserves of coal and other minerals, an industrial railway system passes through five of the nine townships in county A. Township C is the nerve center of transportation for the county. Buses connect every township in the county by no more than a two hour trip. Township C is located at the middle between township A, the county seat, and county A. Comparatively speaking, the transportation net work in this county is relatively efficient and well managed. Like in any other typical county, this county is inadequately equipped with health and medical facilities. There are three townships which remain doctorless. There are eight medical clinics and as many drugstores, but they are concentrated in only a few townships. Therefore, for the health and medical care, as well as for family planning services, inhabitants must heavily depend on the county health center.

PERSONAL CHARACTERISTICS OF DIRECTOR KIM AND SENIOR WORKER PARK

Dr. Kim, who is in charge of the family planning as well as the community health program, first began his duties in July, 1974. Before his arrival, the health center directorship

had been vacant for more than one year. The administrative sub-section chief of the health center, under the close supervision of the chief of county internal affairs, was conducting the health care program. By age 35, director Kim had graduated from medical college and served in the army as a surgeon for five years. Upon discharge from the army, Dr. Kim was assigned to this post. During the military service, he also attended the graduate school of public health, majoring in public health administration. He is apparently a diligent, ambitious man who attained a high level of academic achievement. He volunteered to become a health center director in order to acquire experience in public health administration. In addition to Dr. Kim, the senior family planning worker, 32 year old Miss Park is also an ambitious, dependable worker who strongly supports him in implementing family planning in this county. She has worked in the health center for more than 10 years now. Upon graduation from nursing school in 1967, not far from county A, she started working in this health center. She was first assigned to supervise the maternal child health program, and then assumed charge of the tuberculosis control program for one year. Since 1970, she has worked for the family planning program in this health center. She was promoted to senior family planning worker about three years ago in June 1973. Since she took over the family planning responsibilities, she has twice participated in an intensive family planning course sponsored by the Korean Institute for Family Planning (KIFP). Along with field worker Mrs. Lee, aged 28, senior worker Park has the most seniority at the health center. There is another field worker, aged 26, assigned to this health center whose name is Miss Oh.

Dr. Kim's Opinions on Management

When he first arrived here, Dr. Kim believed that the role of the health center, unlike that of the general hospital, was disease prevention rather than treatment of patients; and he always gave priority to preventive medicine rather than curative medicine. For the effective promotion of health center activities, he supported the use of technical and para-medical personnel. He tried to provide an environment in which the para-medical personnel could effectively carry out their duties. For the establishment of such an environment, Dr. Kim thought it was important to establish an orderly atmosphere and a clear hierarchical structure among the members of this health center. He heeded the fact that the health center is different from a general administrative organization both in its purpose and in its characteris tics. Therefore, order must be established within the framework of priority given to public health activities and to para-medical personnel. His guidelines for management just described were at first a little troublesome, but the problems were easily dissolved. Miss Oh, for example, claimed that the priority given to program activities and technical personnel made their jobs much easier to carry out. Though he is relatively young, Dr. Kim is meticulous about his responsibilities. He even pays attention to problems involving car dispatches and other personal problems of staff workers. But this type of health center management occasionally results in an unexpected uproar. Miss Oh gave a typical example. In April 1975, Miss Oh was instructed to go out to township S, a mountainous area, to insert intra-uterine device for eligible women. She requested a

transportation dispatch for this purpose to the health administration sub-section. Suddenly, the trip schedule was almost cancelled. The story behind the near cancellation follows. The health administration sub-section chief was asked by the county office to provide transportation to take care of an official from the provincial headquarters who was visiting the county on a supervisory mission. When she was told of this story, she went directly into the director's office to get her travel order approved. During the process of reviewing the official travel order, Dr. Kim realized the situation, and instructed the administrative sub-section chief to go ahead as scheduled, assuring him that he would take responsibility for any consequences of not providing transportation for an official from the provincial government. Because of this action by the director, some of the regular administrative staff complained because they thought close coordination with the provincial government was important in order to receive their support in other administrative matters. In response, the director strongly said that even though administrative coordination between superior or other organizations was important, it was even more important to conduct health center duties as assigned. He also emphasized support and cooperation with the local community, but tried to persuade those dissenting staff members that health center duties must be given top priority.

Despite the director's effort to quiet complaints, some of the administrative personnel of the center, including the administrative sub-section chief and other administrative staff, grumbled, arguing that the problem was the director was too young and inexperienced.

Through persistent negotiations Dr. Kim was given, in

January 1975, the authority by the county chief to replace current center personnel including those assigned to the town and township, with personnel he recruited. This turned the tide in favor of the director in wielding his leadership in the health center. As a result, various complaints about the director's leadership gradually subsided among the staff personnel, and they began supporting the director's management principles. The first change Dr. Kim attempted to initiate was to acquire the authority for the health center director to employ and discharge all health workers. Unless the director has this authority, he cannot control the health personnel nor can he boost staff morale, according to Dr. Kim. Over the years the director persistently tried to persuade the county chief to delegate this authority to the health center director, even though he was freqently accused of trying to grab too much power. But the county chief eventually recognized the director's role in the welfare of the community, and accorded him this responsibility.

In the process of managing the center, the director consistently urged direct and voluntary participation on the part of the staff workers. Since his arrival, the family planning program has more or less been mostly carried out by family planning field workers. According to senior worker Mrs. Park, he gave her the responsibility to manage the family planning program, except for personnel appointment and other than standard operational procedures. The director checks the work after it has been done in the field.

When she was assigned the responsibility to implement the family planning program, Mrs. Park was under constant pressure to do it better than others, and she sometimes felt overburdened. However, she felt competant and comfortable when she participated in a group campaign in township D

in which all of the field workers took part in the summer of 1975. It began at a monthly meeting in which the achievement of each Myon was evaluated. It turned out during the evaluation meeting that township D was lagging far behind other townships in enrolling eligible couples for family planning practice. Township D used to be assigned to a field worker by the name of Miss Park who had resigned to be married. To replace her, 20 year old Miss Kim was appointed last April to lead the township in family planning. However, she was not familiar with the family planning program, and she was too shy to discuss family planning with eligible women. During the monthly meeting, many various new ideas were discussed in order to improve the family planning achievement level in township D. In order to improve family planning activities in township D and to provide on-the-job training for Miss Kim, it was decided to conduct a group campaign in township D in which all county field workers would participate. At that point Dr. Kim voiced his approval, saying it had three major advantages; the group campaign would provide 1) on-the-site training for the workers, 2) development of cooperative spirit among the field workers, and 3) an opportunity to catch up with other townships in terms of the proportion of family planning acceptors. This group campaign went on for four days in township D in which all the field workers and administrative workers took part. All the logistics of the campaign were handled by the director.

MONTHLY MEETING OF HEALTH CENTER A

Like other health centers in other counties, the health center in county A holds a monthly meeting. Unless a spe-

cial problem arises, the director without fail takes part in these monthly meetings, and he urges other administrative staff, including the health administration sub-section chief to participate also. The operational procedure of this monthly meeting has changed since Director Kim took over the directorship. In the past, the health administration subsection chief used to preside over the meeting and the topics of discussion were limited to the evaluation of progress reports and health center rules and instructions. It was rather a formal meeting. But Dr. Kim directed the senior work to preside over the meetings, and had her explain about the ultimate goal of general public health services which in turn will help promote the welfare of the local population in particular and that of the country in general. At the same time, the director participated in panel discussions with field workers, without hesitating to ask direct, challenging questions to the workers. He always tried to arrange the meeting in the form of a discussion forum.

Since the senior worker was promoted to her current post in 1973, the field workers have made it a habit to contribute 500 won each to have a lunch together after the lengthy meeting. When money is left over, they save it to purchase mementos for field workers who retire or resign. The lunch and gift program was first designed by the senior worker to create a friendlier atmosphere among the field workers. Since Director Kim took over the post, the length of the meeting was expanded by holding it on saturdays when the workers have more free time. Gradually, Director Kim as well as the public health administration sub-section chief started to take part in this lunch meeting and from time to time shared talks about family planning. According to the senior worker, the real monthly meeting starts after the

lunch meeting, even though the meeting formally starts in the morning. A kind of rap session tends to develop after the lunch from which everyone benefits.

CASE OF HEALTH CENTER IN H COUNTY

At the entrance of the health center is public health administration sub-section office, one will find a special office space separated by a wall at the left side. This is the family planning counselling office. It happened early one morning three days after I first visited this health center that the senior worker, Mrs. Kim, was found trying to explain something to her immediate superior, chief of the public health administration sub-section. She was trying to get approval for an official trip to township C where a group training for the Mothers' Club members has been held every three months at the township office. It was part of the annual routine travel schedule. The family planning program in this township was lagging behind other townships. In an effort to boost morale for the Mothers' Club members and accelerate family planning activities, this senior worker wanted to take advantage of this occasion for a group training session. But the public health administrator denied her request and instructed her to work in the office in preparation for the forthcoming inspection of center activities to be conducted by the provincial government authority the following week. She was trying to persuade her immediate superior to approve the official trip in question, stressing its significance. After 30 minutes of unsuccessful argument with her superior, she retreated, feeling dejected, carrying a bundle of inspection related documents.

GENERAL STATUS OF HEALTH CENTER IN COUNTY H

The health center which is under the jurisdiction of county H is located in the eastern area of province C, and like county A it is mountainous with rugged terrain. It is a small county with a population of 73,005;36,864 males and 36,141 females. The population is composed of 12,042 households with 8,932 eligible women as of the end of 1975. Ninety percent of the inhabitants have agricultural jobs, and like county A, their level of income is below the national average rural income. Though a national highway which connects city T in the north and city C, the provincial capital, in the south, passes through county H, the general transportation condition is relatively poor and quite similar to that of county A. Health and medical facilities of county H are as poorly equipped as those of county A. There are four medical clinics; three of which are operated by semi-qualified doctors, and eight drug stores in this county.

Two townships in this county still remain doctorless. Therefore, for most health and medical benefits including family planning, the people in this county tend to rely mainly on the health center, as in the case of county A.

PERSONAL CHARACTERISTICS OF DIRECTOR MOON AND SENIOR FP WORKER, MRS. KIM

Dr. Moon, the 60 year old director of this health center, is a graduate of a Seoul medical school. He was appointed

as director of this health center in February 1975. Previously he managed a medical clinic in township C, the county seat. At that time, his age interferred with the successful management of the clinic. Then he heard of a vacancy for the directorship of the health center in his hometown, and his acquaintances persuaded him to accept that position. Dr. Kim's personal interests include calligraphy, and he has held several exhibitions a year with his fellow calligraphers of his talented work. Dr. Moon says that he is not getting along very well with public officers in this county H, primarily because of the difference in interests and he feels more lonely in this new position than he expected.

Senior worker Mrs. Kim, age 33, has been engaged in family planning work for this health center since 1966, the beginning of this program. Qualified as a nurse assistant, she is called an expert in family planning in this small county H because of her training as a family planning field worker. Miss Suh, who works as a family planning field worker under Mrs. Kim, also holds a nurse assistant license. Since 1972, when she was 20 years old, Miss Suh worked in the maternal-child health program in township H where the county seat is located. Then in 1974, she was assigned to work in the family planning program in this health center. Her duties usually include filing or counselling eligible women in order to help senior worker Kim.

DR. MOON'S OPINIONS ON MANAGEMENT

Dr. Moon believes that the role of the health center in rural areas is identical with that of a general hospital in the township. As there are almost no facilities and medical specialists to provide medical attention to villagers in rural

areas he believes the health center system is the only way to meet this deficiency. The belief in this function of the health center is supported by the fact that the government assigns medical doctor to a health center directorship rather than a general administrator or health administrator. Dr. Moon strongly insisted that priority should be given to treatment of patients in county H where there is no other medical facility instead of giving priority to preventive medicine or public health administration. Since he was assigned to this health center directorship in February 1975, Dr. Moon has paid special attention to treating of poor patients, issuing health clearance cards, deciphering X-rays, and providing inoculations. He seems to be not interested in health education or public hygiene. Senior worker Kim pointed out that Dr. Moon gives little heed to the family planning program. His opinion is that the family planning program can be conducted by public officers in charge of general administration with the help of para-medical personnel.

Director Moon, however, always accomplishes the task he is interested in, even if it normally is the duty of the public health worker. For example, inoculations such as BCG are usually performed by the public health worker, including the tuberculosis worker, maternal-child health worker, and family planning field worker. The director usually expects only limited work performance from the public health workers. They are assigned nominal duties such as sterilizing injectors and other medical equipment, while Dr. Kim himself gives injections to patients. This practice, a tuberculosis worker by the name of Miss. Kim stated, resulted basically from his distrust of the ability of the nurse assistant who is not equipped with a nurse license.

When he has free time, he frequently travels to near by city C, to enjoy his hobby with his fellow calligraphers. His perception of the role he must play as director of the health center is to treat patients and acquire budgetary support from the county chief when necessary. In fact, Dr. Moon entrusts much of the health center work to the chief of the health administration sub-section.

PERSONAL CHARACTERISTICS OF SUB-SECTION CHIEF KIM AND HIS VIEW ON ADMINISTRATIVE MANAGEMENT

After having served as chief of the industrial administration sub-section at H county office, Mr. Kim was transferred to the post in charge of public health administration sub-section at the health center in November 1975. Sub-section chief Kim, now 45, started his career as a clerk at township D about 20 years ago. Except for five years spent working in neighboring M county, he has spent his life as a public servant continuously in H county and as a result knows H county very well. Kim tends to prefer group meetings in the management of the family planning Mothers' Club. He says that one of the most annoying in organizing a group is how to get eligible mothers together for a meeting. He went on say that unless he himself is present at the meeting, officials of the township (myon) seldom cooperate in gathering people together for a family planning group session. Therefore, he tries to participate in every group meeting, but complained that he is overburdened with other administrative duties which frequently prevents him from doing so. In view of his long experience as a career officer, he states that the most important thing in public affairs

the government is confirmation of what has been done in the field. He used the field worker's activities in the field as an example of confirmation. According to Kim, since a field worker will be beyond his administrative control when she goes out on a fieldtrip, post confirmation of her activities at the field is necessary. Therefore, he thoroughly checks out field activities upon the field workers' return. However, senior worker Mrs. Kim has something to say against such a thorough check of field activities, saying it creates bad feelings and mistrust among the field workers. She says it is typical to recruit only five to seven acceptors, including intra-uterine device acceptor during a one-day field trip. The administrative chief, unsatisfied with this achievement, frequently questions why a field worker can supply contraceptives to only five households, arguing that one field worker should make at least 20 household visits a day in view of the time allocated for a field trip. He thoroughly checks the time and places visited one by one. Moreover, the senior worker tries to send a low achieving field worker for refresher training, she has hard time explaining and persuading the health administrator to permit it. Whenever she tries to persuade him, he retorts back that it is a waste of time and money to send her to Seoul for refresher training in view of her inability to achieve the assigned target. Unable to persuade the health administrator, the senior worker lamented the fact that there has been no health center director nor health administrator in H county ever since her first assignment to the center who has understood or concerned with the significance of family planning. The senior worker claims that their indifference to and misunderstanding of the national family planning program has resulted in her not being allowed to have a private

room for a contraceptive counselling office. The office is shared with the public health administration sub-section, and is very inconvenient for eligible women to receive counselling there because it's not private. Because women are conservative and traditional, they tend to come in to the office where there are health center officials, especially if officials are male. The senior worker said that one woman came to the health center's main entrance and hesitatingly beckoned to the worker to come out of the office for family planning counselling. She claimed that one of the reasons why this health center is lagging behind in achieving targets may be due to the inconvenient location of the counselling office. Therefore, she has recommended time and again during evaluation meetings to create an independent counselling office. The health administrator rejected this recommendation on the basis that there is no alternative due to financial limitations of the center. Because she is well aware that the center has very limited working space, she recommended to the health administrator then to assign an independent and separate office for family planning workers, maternal-child health workers, and tuberculosis workers, all female, to share. This suggestion was also rejected because each worker is under the control of different sub-sections and confusion in supervision may arise if all of the health workers are placed together in one office.

There is only one designated medical doctor who is authorized to perform the vasectomy surgery and to insert intra-uterine devices in H township. Since the residents are widely dispersed, it is difficult for them to take advantage of medical attention from this clinic. In light of this disadvantage, the senior worker asked last May that additional medical doctors be designated to perform the vasec-

tomy surgery and to insert intra-uterine devices. However, he flatly rejected recommendation, saying that whether to designate a doctor or not is his duty given him by the

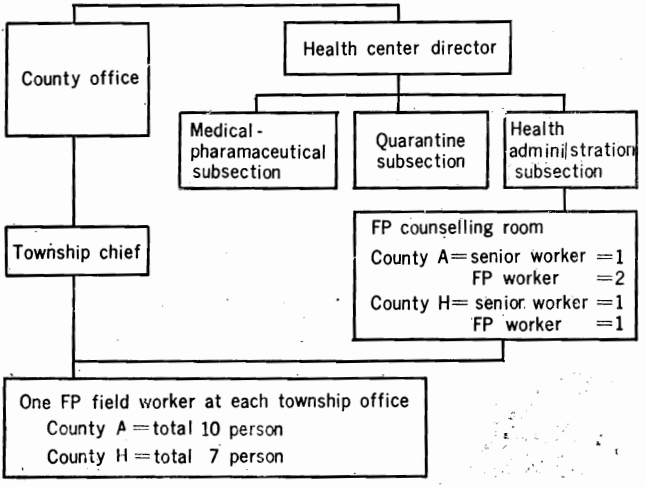
Appendix 1. Family Planning Program Achievement of Health Center Indicated

(July 1st 1975~June 30th 1976)

Health center	Number of eligible women	Number of acceptors	Number of acceptors by method					Number of acceptors per eligible women
			Loop	Oral pill *	Condom *	Vasec-tomy	Tubal-ligation	
A	16,214	4,167	1,246	1,654	938	135	149	25.7
B	8,932	1,001	425	216	288	39	33	11.2

* Average per month

Appendix 2. Organization Structure and Family Planning Delivery System in Health Center (Health center A and H are identical)



government authority, and not part of the senior worker's considerations.

And he roared back that, "This is none of your business, and I will take care of this problem." No action has been taken since. He may have totally forgotten it. The senior worker feels that the health administrator thinks the target for eligible women should be achieved through formal, as well as administrative coordination. An example of this happened last September. In an evaluation meeting in which the IUD target achievement by township was evaluated, it was found that township D was well behind the target of 182 cases; achieving slightly less then 100 cases. This happened when the field worker in charge of township D became sick in July and did not recover until September. The senior worker interviewed Miss Min and asked whether she could still achieve the target by the end of the year. She answered that she might be able to achieve 30 cases less than the assigned target. The senior worker then, in view of this situation, reallocated 15 cases each to township H and township K where IUD insertions was quite high and there were large numbers of eligible women. After hearing about this readjustment, the health administrator called her to his office and reprimanded her for making this decision without his consent. She attempted to defend herself by reminding him the reallocation of target cases among townships was a responsibility delegated to the senior worker, and was determined by the local situation.

Kim, Kwang-Woong Ph. D.

CHAPTER 9

A Health Clinic Indifferent to Inter-Agency Coordination

External Linkage Case

In 1974 Ms. Yu, the senior worker for the family planning program was reviewing the advisability of the group oriented approach that she had long been espousing as the special strategy for the family planning program in a county in the northern part of Choongchungnamdo. Ms. Yu had only been assigned in the county for three months and she had been quietly establishing links with some community organizations, principally, the Saemaul Undong (New Village Movement in Korea), the Military and the Mothers' Clubs against the wishes of the health center director.

Ms. Yu was wondering whether her approach was proving effective in contrast to the traditional "individual approach" that was characteristics of the national family planning program. The ultimate test, she felt, was given the limited resources of her time and the health workers' time, how many more acceptors were brought into the program. She realized that it was important for her approach not to fail

because her superiors were constantly asking whether she met the family planning targets.

Finally, Ms. Yu was wondering how she could get the higher officials of the health center to support her approach if it proved effective. Contacts with the community groups required the participation of health officials that were higher in rank than her. Consequently, she would have to methodically convince the others in the health center team of the advisability of the group approach.

Ms. Yu recalled the shiny day in early spring, when the thawing season had just been setting in that she arrived at the health clinic.

A health clinic worker greeted her and she was dubious whether her attitudes covertly appeared to be sarcastic a sharp contrast to the physical atmosphere of the health clinic.

The new building of the clinic was elaborately made up, and encouraged her to work harder than ever. Passing through a long aisle, she was led to the director's office where she reported the director and the sub-section chief of health administration of the clinic. The director ceremonially welcomed her and then warned without preliminaries that it was a critical time for ensuring the achievement of the IUD target. The sub-secion chief stared at her expressionless. "The words, the target achievement entirely depends upon your capability", were still ringing in her ears as she withdrew from the room and went up to the Family Planning Office located in a cozy corner of the second floor of the building where she was briefly greeted by other colleagues.

It was the second time for her to work as a senior worker at the county clinic office in her relatively short period of experiences. Ms. Yu was only 29. With less con-

fidence owing to few experiences, she had to adjust herself to the unfamiliar organizational climate of the clinic and to implement the assignments piled up on her desk. During the vacancy of the post such duties as monthly report, coupon check up, field supervision and campaign, and so on were done by one of health clinic workers.

After taking her place, as a new comer, she tried to assess the characteristics of the organizational climate---clear or cloudy? She was not able to obtain an immediate answer, of course.

BACKGROUND

The health clinic was located adjacent to the county office in a same complex, which was conductive to frequent contacts between the staffs of the two offices.

The total population of the county was 132, 935 with 68, 016 male populations and 64, 919 female populations among which the number of married women of reproductive age were approximately 4, 000 persons. There were 24, 359 households primarily engaged in agriculture who lived in clusters within an area of 570. 6 km^2. The population density of the area was 233 per $1km^2$.

As an administrative unit, the county had one Eup, and twelve Myons (towns) in which there were 404 natural villages. Thus there were 13 family planning workers each serving a Myon. The average number of households the family planning workers took charge of was 1, 873. Though it was estimated the numbers were much smaller because the target population was low.

In the clinic two nurses and two aid-nurses were engaged in the family planning activities. They were sometimes

Figure 1. Organization Chart of the Health Clinic

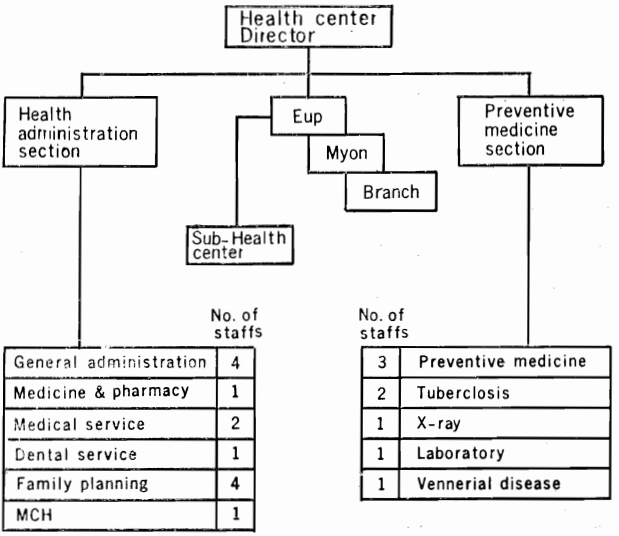
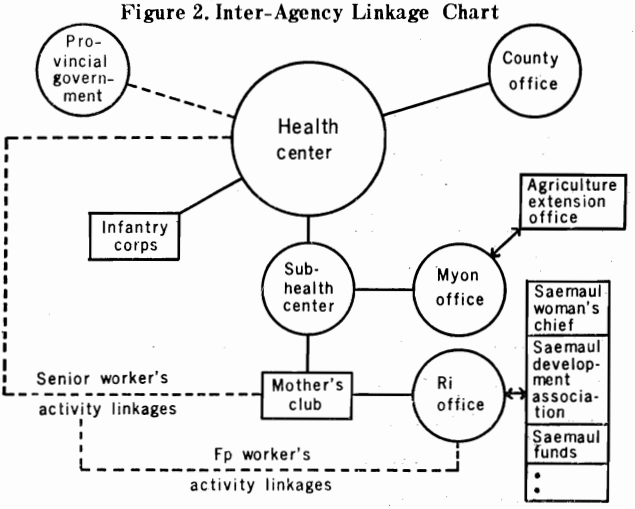


Figure 2. Inter-Agency Linkage Chart



supported by other nurses in other sections of the clinic and vice versa. In total, there were 24 staffs including director and two sub-section chiefs working under the apparatus of health administration section and preventive medicine section. Most of the workers were non-regular staff members whose job security was shaky. (see Figure 1)

In recent years one characteristics of the FP activities in Korea was that FP workers were not exclusively working for the program, but were from time to time recruited to other clinic activities such as MCH, TB, and furthermore to Saemaul Undong. This trend implied that the clinic administration was not confined merely to itself, but also had a lot of activities with the county administration. Initially, the administrative mechanism between the two institutions was set up in such a way that personnel and financial management of the clinic was provided and supervised by the county office. The power dynamics between the two organizations and their people and the requirement of the Saemaul mobilization necessiated and accelerated the close relationships.

In general, it had been widely known that the participation and support of the county office on FP activities was greatly conductive to the productive performance of the program. In fact others pointed out that the success of the program almost relied upon the support of the county administration.

One special characteristics of the region was the presence of an infantry corps. The soldiers' families were living in a complex. The clinic considered the infantry as a good source of family planning acceptors, although they were highly mobile. It was quite obvious that with the help of

the military forces, the clinic would be able to achieve the target with greater ease.

The level of performance of the clinic was on the middle range by the national standard. The clinic placed heavy emphasis on the increase of IUD and vasectomy acceptors in accordance with the national program measure.

THE KEY DECISION MAKERS IN THE HEALTH CENTER

The section chief, namely Kang, has been a career officer in provincial government. As an old timer servicing more than 30 years in local government he knew how to manipulate administrative mechanisms on a lower level. With a strong personality of his own, Mr. Kang would interfere in health administration so long as it was somewhat related to the county administration. Under such circumstances, Mr. Lee, the sub-section chief of health administration of the clinic, was most of time submissive to Mr. Kang. Their relationships were so close that issues of health administration was usually settled by them.

The county chief, Mr. Park, had been virtually indifferent in community health programs. He would meet the clinic director, Dr. Kim, once a week when regularly had the local directors' meeting. Topics and issues they used to deal with at the meeting did not include a health program. The county chief would only occasionally ask the clinic director "to what extent had the target been achieved in this month and so on?" If sometimes the clinic director wanted to report something to the county chief outside the regular meeting he would wait for him for an hour; and sometimes the appointment would be cancelled because of

an unexpected schedule of the chief.

Actually, the clinic director was also not too concerned with the FP program in the clinic. Although he did not avoid treating patients, he was not very enthusiastic. His ultimate aim seemed to be the establishment of his own clinic whose clientele would be based on his personal relations built up through the office careers. For this purpose, he often contacted the county officers outside the office. He believed that extra-office activities might facilitate personal relations closer, for which he invited county officers to "Daepo". (metaphor of drinks in Korea)

Dr. Kim at the age of early 50's had not been educated at a regular medical college. When he was mobilized to the military service in the era of Japanese domination, he had an opportunity to learn and practice medicine. With that experience and after his discharge from duty, he passed the qualification exam to enter the medical professions. While others may have assessed his professional career as unsuccessful in comparison with other professionals of that era, yet he had contributed heavily to the improvement of community welfare. During the 27 years of his career, he has served quite a few times as clinic head in local communities. He was generally considered authoritative in his dealing with his sub-ordinates and was known to impose heavy assignments upon them. Some staff members complained that he was reluctant to listen to their problems. Decisions were usually made by himself without consultations of staff members involved.

In his dealings with the county office, for example on FP worker allocation, budget estimates and so on, he was always obedient. Whenever he was frustrated with subordinates and other management problems, he would complain,

saying that "sooner or later I will guit the job and will open my private clinic. That is a short cut way to make money."

FAMILY PLANNING CAMPAIGN IN A GROUP APPROACH

As Ms. Yu tried to get more acquainted with the clinic climate, she also tried to more deeply understand what were the barriers to the program performance. One of the observations was soon tested in a argument with the clinic director.

At the end of every month the senior worker together with 13 FP workers were supposed to report and self-evaluate monthly performance of the program to the clinic head. At such times, they reviewed strategies of persuasion and enlightenment on acceptors as well as the amount of achievement. It was here that the clinic head criticized the "group approach" campaign strategy. The director considered the group approach was impractical and moreover through the campaign people might be ridiculed by neighbors who had bad experiences. However, Ms. Yu felt that it was inevitable to employ the group approach to reach IUD acceptors in particular, because individual contacts were not sufficient to achieve the target. Potential acceptors were in as scattered households in remote and mountainous villages. Moreover, the heavy work loads of FP workers made the employment of the group approach very attractive.

Dr. Kim reiterated his firm belief that in particular the IUD campaign in a group approach might produce poor impressions on potential acceptors. Meetings could include IUD acceptors in the past who had experienced severe side

effect. Therefore, if people got together to be enlightened regarding contraceptive methods, the mass psychology may worsen the misconceptions prevailing among the people. So his assertion was that like guerrilla war strategy, FP workers ought to get in touch with villagers one by one so as to get rid of false ideas.

The approach of the campaign suggested by Dr. Kim was not agreeable to Ms. Yu. In principle, it was apparently true that face-to-face contact to persuade acceptors was relevant and practical. Theoretically she knew in what way it should be done. However, under such circumstances as a shortage of personnel and financial resources and the lack of an adequate transportation system, it seemed almost impossible to attain the given targets. Furthermore, she expected that IUD and vasectomy methods would rise in acceptance in the spring time. Ms. Yu, aware of this pattern of contraceptive acceptance, wanted to marshall as many of her resources during thet period. She felt it only fair to be allowed her way and thus be evaluated properly.

In the past, she was able to request related agencies that had meetings with people for one hour or more to talk about the FP program. In fact there were lots of occasions mobilized by the county office, through which they were able to communicate with local populace. For example, villagers were supposed to have meetings to discuss about the use of Saemaul funds, to discuss about planning of projects to be undertaken in the village, and to be informed about government policies once a month. In such occasions, FP program could find a place to inform target groups about the need for family planning and the services of the FP program.

In addition, there was a good base in the infantry corps

for the program to be able to extend. Married military personnels who lived around the corps could be a pertinent target group.

In case of inter-agency contacts and coordinations, the health center director was expected to initiate and deliver the messages to other agencies for the better management of the program. She wanted the director to value her idea and to help it come into being. The director's belief was so rigid that she temporarily gave up obtaining permission.

In the long run she tried to find out alternatives which could be realized without director's support. She was convinced that she had to implement group approach program by herself, and yet other persons to help her. An assistance she could obtain was from the president of the Mothers' Club, which had the FP program as one of its activities.

SUPPORTS FROM OTHER AGENCIES

Ms. Song, the president of the Mothers' Club, was a kind and active woman who was always of great help to FP program activities. She kindly guided young FP workers to village meetings and let her campaign about FP program to the participants. Of the many activities the Mothers' Club, had Ms. Song placed most emphasis on FP program.

The senior worker decided to visit her to ask her help, informing her of the disagreement with the director. After listening to her serious problem, Ms. Song promised to support her. As a first step, she provided FP workers with meeting arrangements with the Saemaul Women's Club and the Saemaul Development Association where FP workers were able to talk about FP programs to constituents.

It was ordinarily difficult to make arrangements with

the Saemaul Club, because an official rubber stamped request from the clinic head was necessary. However, Ms. Song was able to mediate for a talk on family planning. Although the structure of the meeting was flexible, it was still exceptional for the Saemaul Club to accede the request of Ms. Song

Another arrangement was made with the aid of Ms. Song again. This time with the infantry corps. The vasectomy and condom methods could be promoted with them. However, the group was not easily approachable, because their activities were usually separated from civil activities. They had their own internal programs and were generally unaccessible from the outside.

Though they still did not have clear idea, Ms. Song and Ms. Yu determined to call on the corps. As they knocked on the door of the chief and explained the objectives of their visit, they sensed unfavorable reactions. His answer was that, because of the tightly structured schedule, they could not be allowed to accomodate the FP program in the existing programs of the corps. Moreover, he personally believed that people were needed in order to confront the communists and that the population was a precious resource to do it. He did not entirely negate the necessity of FP program, but he was passive about sharing their hours with the FP program. The visitors had to return back with no results.

After returning, Ms. Song and Ms. Yu practically tried to come up with alternatives. An idea evolved that they could make use of the isolationism that had been characteristics of civilian-military relations. Thus, they made a decision to purchase packs of Hi-Ti (detergent) to console with soldiers. They took the products to the corps as other welfare

organizations did and donated them to the official. He gave a big smile, yet hesitated to receive them. Sensing his awkward attitude, the visitors simply stated that the purpose of their visit was to contribute to improving the morale of the military, which was one of the extra-curricular activities of the Mothers' Club. Then the chief gladly accepted.

One day about a week later, the president of the Mothers' Club happened to meet the chief on a street. They were pleased to meet by accident and at his suggestion, they stepped into a coffee house for a chat. She was convinced that it was definite chance to persuade him to be inclined to the FP program. Outskirting the issue, she implicitly contended that the population crisis nowadays in this country appeared to be very serious. A confrontation with communists backed up with prominent manpower resources could not be overlooked, but she continued, the population increase definitely was an obstacle to economic development. She asserted that it was the economic development policy that we could be enriched through economic growth so that we could be strong enough to overcome the opponent. She sensed that the chief was slowly reviewing his attitudes.

The president of the Mothers' Club called up the senior worker about the good news, which made her very excited. They decided to make a visit him again. Eventually, the corps chief allowed Ms. Yu to campaign the FP program.

In the spring time, the cooperations of other agencies had lessened her burdens. She was very grateful to the Mothers' Club president and others who had helped her a lot.

Nevertheless, she was in a serious dilemma. Although she had carried out her assignment by many means, the process was haphazard. If everything was unsystematic she might be having similar problems in the future. She felt that if such problems could be surmounted, the effectiveness of the program might be higher than ever. Her hope was to make the internal staff members understand and coc per-ate with the FP activity so that she could be backed up by endogenous resources. If such a milieu could be established, then external assistance could doubly be effective in implementing the program.

She was wondering whether she should persuade the sub-section chief of health administration about her approach. She doubted whether she could change the mind of the health center direction. In contrast, the sub-section chief seemed simple with no professional value judgements. "Getting things done" was all thing that he was concerned with. While she wondered about approaching Mr. Lee, she asked herself again, "Am I moving the family planning program in the right direction? How can I systematize the process? Should I work harder at convincing the other ?"