SYSTEMS ANALYSIS AND INFORMATION NEEDS ASSESSMENT OF THE KOREAN NATIONAL FAMILY PLANNING PROGRAM

Interim Report of A New Scheme for the Improvement of Family Planning Information Systems and Quality of Family Planning Program Statistics
(UNFPA/ROK/77/P04)

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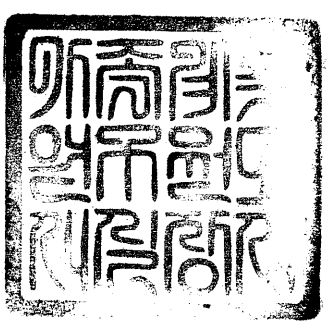

Preface

The Korean national family planning programme has been successful in the last fifteen years in its important role in bringing down the birth rate and the rate of population growth. The population growth rate decreased from approximately 3.0 per cent in 1960 to 1.7 per cent by 1975. The new target for the fourth-five year plan (1977-1981) is to achieve an annual population growth rate of 1.6 per cent by 1981. However, future progress will face many stumbling blocks arising from several unfavorable socio-demographic factors. These include the rapid increase in eligible women born during the baby boom early in the 1950s, the traditional male child preference, and the change in the age at marriage.

In order to cope with these increasingly unfavorable socio-demographic conditions the Korean national programme must review its past programme implementation strategies. The present work is one part of this effort now being undertaken by the Korean Institute for Family Planning.

Taek Il Kim
Director

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I. Introduction

The Korean national family planning program was inaugurated in 1962 and is now reaching maturity. Most of the original goals of the program have been met. Knowledge of and favorable attitudes toward family planning are universal. Fertility has declined dramatically and family planning practice rates are among the highest in the developing world. In the past, concern was primarily focused on program impact. The government needed to know if Koreans would adopt family planning and if the program could have a positive demographic effect. Accordingly, research and evaluation came to rely almost entirely on sample surveys rather than on service statistics, reports and records. Moreover, the information obtained through the service statistics system was designed to meet the needs of research personnel rather than the needs of planners and managers.

The concerns of the national family planning program have expanded beyond those of impact. It is now important to evaluate the efficiency of operations, to monitor the quality of services provided and to identify operational problems as they occur. A number of factors make the service statistics system inadequate to the tasks of identifying administrative bottlenecks and supervising field operations. Only two kinds of data are contained in the reporting system, target achievement and acceptor characteristics. The data that is collected

is not analysed, interpreted or circulated to administrators on a regular basis. Rather the data appears only in year-end summaries or special reports. In addition, fieldworkers and other program staff are also required to keep a large number of records of unknown utility and questionable quality.

As a result of these problems, the national family planning program has launched a project to replace the existing service statistics system with a broader management information system (M.I.S.). The goals of the M.I.S. project are:

1. To improve the management of the Korean national family planning program.
2. To make the overall evaluation system of the Korean national family planning program more responsive to managerial needs.
3. To modify the service statistics system so that the information it contains is more useful to all levels of program personnel.
4. To provide managers, supervisors and workers with information at regular intervals that will help them monitor program effectiveness, efficiency capacity and quality.
5. To simplify existing forms and records so that reporting and record keeping is made less time consuming and difficult.

6. To improve the quality of data now produced by the service statistics system.
7. To train program personnel in managerial techniques based on the use of the M.I.S.

At its most general, the project will determine the information needs of different administrators and organizations within the national family planning program, broaden the spectrum of the data provided to meet these information needs and train managers to use the system to improve the performance of their units.

The present study is the first step towards creating the management information system. The objectives of this systems analysis are:

A. To describe the goals and structure of the Korean national family planning program.
B. To review program inputs to determine the types of coverage and efficiency indicators that are relevant to the program.
C. To review the status of program outputs to determine necessary levels of acceptor monitoring and to determine appropriate effectiveness and quality indicators.
D. To examine major program problems to determine if their solution could be facilitated by information supplied by an M.I.S.
E. To describe the existing service statistics system so that its form, strengths and weaknesses are understood prior

to making recommendations for its alternation.

F. To describe the jobs of program middle managers, their qualifications and present service statistics information use patterns to help determine the sort of information middle managers could usefully receive through the M.I.S. and to reveal the data that could be eliminated from the new system.

G. To describe the responsibilities of central level program components to determine the type of information needed by these units.

H. To make recommendations for the design of a new system.

Definitions:

Throughout this report, references will be made to indicators of various kinds. Indicators are service statistics that alone or in combination with other data such as an objective, target, population denominator or other service statistics provide an objective assessment of program progress. Indicators can provide information on almost any aspect of a family planning program including manpower, acceptors, contraceptives distributed, etc. However, any indicator will fall into one or more of the following catagories:

1. Volume Indicators refer to measures of such items as the amounts of services rendered, the numbers of facilities and personnel employed,the amounts of money spent and the numbers of clients served.

In short, any item of activity or service support that may be counted and summed is a potential volume indicator. Volume indicators are used as a guide to the magnitude of a service provided.

2. Coverage Indicators refer to measures of the extent to which services are provided to various groups in the population to be served. In effect, many coverage indicators are volume indicators related to the appropriate population denominators.

3. Quality Indicators, most of which are indirect, include a variety of measures. Of all the categories of indicators, some of those dealing with quality are the most difficult to establish. These indicators cover a broad range of concerns not usually approached through the analysis of service data.

4. Effectiveness Indicators refer to measures of the extent to which services of the MCH/FP program are contributing to achievement of stated program objectives.

5. Efficiency Indicators are measures which relate other indicators to units of input. The most commonly used are cost units, but occasionally others are employed, such as personnel or facilities.

II. Methods

A variety of methods were employed in the systems analysis because no single method was appropriate to carry out every task and because no single method was thought reliable enough to provide an accurate assessment of information needs. Official documents and reports were reviewed to determine the goals, essential organizational components, inputs, problems and future direction of the national family planning program.

A committee of middle managers was formed to furnish information on the record and reporting systems and to assist in the design of a new system. Project staff interviewed middle managers to produce job descriptions that could be used in determining information needs.

A self administered questionnaire was designed to elicit the following information from middle managers and fieldworkers. 1) job activities 2) official and unofficial forms and records used 3) information value of items contained on the forms and records, 4) utilization of data 5) time spent on record keeping 6) information wanted 7) general level of knowledge of management techniques. The questionnaire was mailed to 647 family planning program workers.

A 100 percent survey was done of family planning sub-section chiefs and supervisors at the provincial level (N=33). The reason for the 100 percent survey are (1) the small number of personnel at the provincial level, (2) the need to acquaint all provincial level

workers with the M.I.S. project, (3) the need to collect all un-official forms developed at the provincial level.

A 100 percent survey was done of family planning sub-section chiefs and senior workers at the county/city level (N=406). The reasons for this are (1) the need to acquiant all county/city level managers and senior workers with the M.I.S. project, (2) the need to collect all un-official forms developed at the health center level.

A 9 percent sample was drawn from the urban neighborhood and rural township fieldworkers (N=2,330, n=203). Sampling of fieldworkers rather than a 100 percent survey was decided on because of (1) the large number of workers in this category and (2) the low priority assigned to a direct contact about the M.I.S. project between the fieldworkers and program management section staff. The sample was drawn systematically from personnel records after a random start. The overall response rate was 79 percent.

As an instrument the questionnaire (see Appendix 1) has many weaknesses. Consequently, attention has been paid only to the differences that appear the greatest and the results that appear to be the most interpretable.

All the official forms and records used in the Korean national family planning program were collected and analysed. The forms and records analysis included four tasks. A form census was conducted

to reveal the number, purpose and routing of forms. A content analysis of the items on the forms and records was completed to determine the amount of overlap between forms and to better understand the emphasis of the forms and records sub-system. To complete the forms and record analysis, the indicators in the reporting system were catalogued. Finally, the major information and activity flows were charted to provide a graphic understanding of the service statistics system.

III. Overview of National Program

A. Goals, objectives and organization

At the broadest level, the reason for Korea undertaking a family planning program can probably be stated as improving individual welfare by improving the health and socio-economic conditions of the nation.

At a more practical level, however, the government has established quantitative goals for the population growth rate. These goals were 2.5 percent for 1966, 2.0 percent for 1971, and 1.5 percent for 1976. The target growth rate for 1981 is 1.6 percent the national family planning program contributes to the achievement of this target by fulfilling the following objectives.

a. To achieve a current contraceptive practice rate of 52 percent of eligible couples in 1981.

b. To conduct information and education activities to produce high levels of knowledge of and attitudes favorable toward family planning.

c. To recruit specified numbers of family planning acceptors every year.

B. Major program components and responsibility:

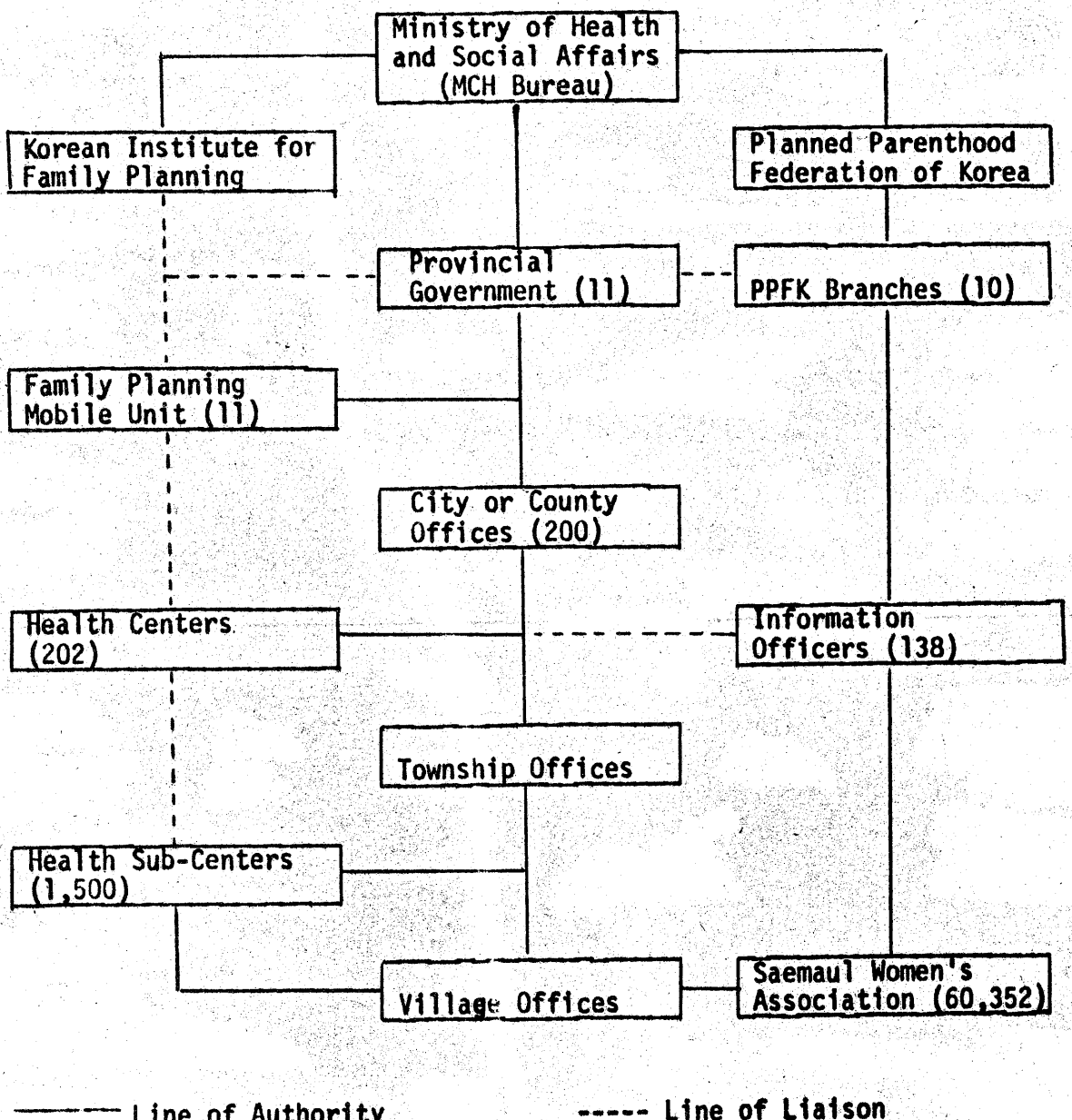
The Korean national family planning program has been implemented primarily by three organizations; the Ministry of Health and Social Affairs, the Korean Institute for Family Planning (KIFP) and the Planned Parenthood Federation of Korea (PPFK). The Ministry is in charge of overall program planning, coordination and control and for the maintenance of the national service network. The KIFP, a semi-governmental agency, was founded in 1970 and was delegated responsibility for the training of program personnel and for research and evaluation activities. The PPFK, a private voluntary association established in 1961, has responsibility for the information, education and communications support component of the national program, including support of the nationwide system of family planning Mother's Clubs set up in 1968. Also, the PPFK has mainteined 15 family planning demonstration clinics, 5 in Seoul city, where they focus on the urban slum areas, and one each in the other provinces.

Actual implementation of the program is done at the provincial level, where the the Bureau of Health and Social Affairs typically Contain a Medical Affairs/Public Health Section, and a Family Planning Sub-section. At this level are found family planning personnel responsible for supervision and administrative functions with respect to lower level health centers. At the county level, health functions

including family planning are placed in the health center, whose director is responsible for all public health and some curative medical activities in the county. The health center director is under the direct control of the county chief, and the technical supervision of the provincial authorities. He in turn controls directly the network of health sub-centers at the town/township level, whose family planning fieldworkers, for example, are supervised by the health center FP senior worker. A loosely organized network of women's organizations that provides social support to acceptors and assistance to fieldworkers and information officers completes the family planning network.

The organization of the program is graphically portrayed in Figure 1 below.

Figure 1. Organizational Network



IV. Inputs

This section will describe those inputs directly related to service delivery. These inputs include fieldworkers, designated doctors, health centers and sub-centers, mobile units, Hospital Clinics, Planned Parenthood Clinics, mothers clubs, IE&C officers and media activity, special projects and funding sources.

A. The Fieldworkers. Fieldworkers are used at two levels in the program. In each rural country there is a Health Center, 138 in all. Each small city, and each ward of the big cities also has a Health Center, adding 64 more for a total of 202. Each HC is staffed with FP fieldworkers. As well, each HC has one FP Senior worker. Within each county their are towns and townships, and each of the urban areas is divided into districts. One FP fieldworker is allocated to each town, township, and district, many of which have a health sub-center (HSC). If there is a functioning HSC, the fieldworker will report administratively through it, although in practice she may base her activities from the HSC, the Government Office (often on the same grounds) or from the office of one of the cooperating doctors. These activities involve:

(a) Door-to-door contact with the eligible couples in her area;

(b) Distribution of condoms or oral contraceptives to those who require them, on a regular basis;

(c) Urging and assisting eligible couples to accept an IUD insertion or reinsertion, or a male or female sterilization. If the couple acceptors, the field worker prepares a coupon which she gives to the couple to take to the doctor named by the fieldworker. In many cases the field worker actually accompanies the woman to the doctor.

(d) Attending and working with the local Mothers' Clubs in her area (discussed in more detail below).

(e) Preparing and maintaining a variety of very detailed records on the couples she contacts and the contraceptive activity with which she is involved, and submitting regular reports based on these records;

(f) Participating in whatever other activities the local Government requires, such as disaster relief, vaccination, drives, etc.

There tends to be a large difference between the activities of the more urban Health-Center based workers and the rural workers, especially at the town and township level. The task of door-to-door contact with an urban population is understandably more difficult, with the problems of locating and contacting people in the densely packed areas, where many of the women work as well, and are not accessible during the day. Addresses are almost impossible to use, making follow-up much harder. On the other hand, the rural workers

obviously are forced to spend a lot of their time travelling, and are much more restricted by weather conditions, making work planning more difficult for them.

B. Designated Doctors. There are currently about 2,000 private doctors who have been authorized by the Government to provide medical services to FP acceptors, and who are paid a fee by the Government for such service. The exact number of cooperating physicians is difficult to determine, and somewhat meaningless, since the list of doctors-ever-authorized would include many who are no longer "cooperating" for one reason or another. In principle, a doctor applies to become an authorized cooperating physician. If his application is accepted, he is send for training. He is then authorized to participate in the program.

Very few new doctors are authorized each year. Authorization is at the discretion of the Provincial Governor, and the MOHSA is informed of all actions taken.

The great majority of the cooperating doctors operate out of their private clinics. A small number have hospital-based practices, and some are in fact associated with a Government Health Center or Sub-center, in which case that Center is able to supply the medical service directly. This is a relatively infrequent situation at present, however, and is limited almost entirely to the insertion of IUD's.

C. Health Centers and Subcenters. The ROKG through the Local Government machinery operates a network of 202 Health Centers, one each in the 140 rural counties, and in the 52 small cities and big city words. As well, there is a developing set of Health Sub-centers at the town, township and city district level. There are somewhere on the order of 1000 of these subcenters now, but at various stages of construction, equipping, staffing and operating. (In contrast, it will be recalled that a FP field worker position is authorized in every one of the 1,473 towns and townships, although of course temporary vacancies exist.)

As mentioned above, this network currently functions primarily as an administrative system for the Public Health activities of the Government. The focus is generally on preventive activities such as sanitation,health education, TB screening, communicable disease control, etc., and there is little clinic-oriented, curative service. There are exceptions to this rule, however. Some Health Centers, mainly in more developed urban settings, do offer simple clinical services, for example, experimental MCH programs have been attempted including pre-natal, delivery, and post-natal care. In addition, Health Centers and Subcenters, as the field workers' base of operations, do of course provide a place where a woman can come and obtain contraceptive supplies and information, or be routed to a cooperating doctor for a medical procedure.

The main function of the Health Center network, however, has been and remains non-clinical and administrative. They supervise a variety of field work programs such as Family Planning, and carry out much recordkeeping and reporting. They also are the logistics channel for health field programs, including any required transportation, commodities and equipment.

Health Centers play an important role in the delivery system, but it is usually administrative, not clinical. Any functioning Health Center or Subcenter, however, as mentioned above can provide the non-medical services (information, condom and oral pill supply) and direct referral to a cooperating doctor for IUD insertion, sterilization or follow-up contraceptive side-effects or complications.

The City of Seoul is a definite exception to this general pattern. A few years ago, for a variety of reasons, the Seoul City administration decided to abandon the use of cooperating doctors within its jurisdiction, and provide all medical services required by the program through its own system of clinically-oriented Health Centers.

D. Mobile Units. The number of Mobile Units which has been as high as 17, does not indicate the actual situation, as the majority, for a variety of reasons, have not been able to operate effectively. The original concept was that these units would travel to doctorless rural areas to provide medical services otherwise lacking. However, the project proved generally to be extremely expensive in relation

to results, and very difficult to coordinate with other field activities.

A number of different attempts were made to reorganize the Mobile Unit Program by changing their affiliation, mode of operation, etc. It is probably fair to say, however, that the answer, if any, has not yet been found.

E. Hospitals. There are more than 200 general hospitals in Korea, of which almost 50 are public city or provincial hospitals. Their involvement in the National FP Program has been minimal until recently. A pilot project to include 75 hospitals directly into the program has met with modest success, and plans have been made to expand this to all hospitals in the near future. Recently announced plans of the ROKG to place hospitals in every county indicate that their role might be significant if an effective way can be found to involve them, both as a service facility, and as a source of potential acceptors of both medical and non-medical contraceptive techniques.

F. PPFK Clinics. A further channel for medical services is the network of FP Clinics established and operated by the PPFK. There are 15 such clinics, 5 in Seoul City, where they focus on the Urban Slum areas, 1 in Pusan City, and one each in the nine provinces. The PPFK is justifiably proud of these clinics, which offer comprehensive FP services in a relatively attractive facility. Clients pay for services by purchasing "memberships" in the PPFK, but this

revenue by no means covers the full cost of the services, which are heavily subsidised.

G. Mothers' Clubs. These clubs, organized by the PPFK, provide a channel for face-to-face communication on family planning, and an opportunity to use small group meetings to combat the effects of rumors and initial contraceptive discomfort. The PPFK announced recently that there were 20,974 Mothers' Clubs in operation, at least on paper, with a total of 287,558 members. Infact, information from a number of sources indicates that of the total number of such clubs formed in principle, roughly one-third were not really functioning at all and another third were operating marginally, still fully a third of them were meeting regularly, and these successful clubs are the most effective tool available to the local fieldworker.

H. Information, Education and Communication. The IE&C activities in the program consists essentially of the Mothers' Clubs operations at the local level, seminars and other mechanisms for influencing community opinion leaders, especially in urban settings, and a program of communication through the mass media. Virtually all of this activity has been delegated to the PPFK.

I. Special Projects. A large number of special projects are conducted with the co-operation of the national family planning program. The majority are short term demonstration projects that test hypotheses about service delivery. In general, demonstration projects are closely

monitored by the experimentors and results are reported through the service statistics system as well as in special reports. A few larger scale projects however, such as the hospital and industrial sites programs do not contribute information to the service statistics system. Indeed, knowledge about the PPFK industrial sites project is so poor that it is not even known how many participants are actually providing contraceptive services to workers.

Among the most important of the special projects is the urban slum project carried out since 1974 under UNFPA support. As of October 1978, there were 20 family planning clinics in low income areas of the major cities including Seoul, Pusan, Kwangju, Taegu, and Inchon. The clinic functions as a sub-health center as in the rural areas and is controled by the health center in the area. The government will extend and strengthen the project in the future.

J. Money. The outstanding feature of resource flow within the FP program is its complexity. There are a multiplicity of sources, channels, and users.

As far as the field program is concerned, money flows from the MOHSA central budget to pay half of the salaries and allowances of the field staff, while the other half comes from the MOHSA Local Government budgets. Incentive fees to workers (for recruiting IUD and sterilization acceptors) and service fees to doctors are included directly in the MOHSA budget, but flow down to the field through the

Local Government. To complicate matters further, several Donor budgets include items applied to the field program, often for experimental or developmental type costs. Similarly, for other agencies such as the KIFP and PPFK: activities they execute are also typically funded from multiple sources, making independent evaluation and control difficult.

V. Outputs

The primary output of the national family planning program is, of course, acceptors. The following section discusses the importance of the various methods dispensed and trends in acceptors.

A. Condoms

1. Present Status

The condom is a major family planning method in Korea, accounting for a constant 10-15 percent of current contraceptive users for the period 1966-1976. Presently, initial and re-supplies of condoms are available from both program and non-program sources. Condoms available from the national program cost 20 Won per package of 6 condoms, while condoms available from commercial sources range in price from 400-600 won per dozen. Despite the price differential, the two sources distribute approximately equal numbers of condoms. Commercial sector condoms are available almost exclusively through pharmacies. Program condoms are available from a wide variety of sources including health centers, health sub-centers, boths set up in markets and other areas of heavy pedestrian traffic, mobile vans, field workers mother's club leaders, saemaul leaders, Ri and Dong chiefs, industrial sites and the regular and home reserve army.

2. Program Direction

The government has decided to de-emphasize condom distribution in favor of more cost-effective methods, especially sterilization.

Program condom supply targets are being steadily lowered while the commercial marketing of condoms receives ever more government encouragement.

B. Oral Contraceptives

1. Present Status

The birth control pill is a non-prescription contraceptive in Korea. It is widely available and very popular. In 1966, pills accounted for less than one percent of contraceptive use. By 1976, the method claimed 18 percent of current users. Since 1976 signs indicate that the popularity of the pill has stabilized. The availability of the pill is almost equal to that of the condom as described above. Users are also approximately equally divided between commercial and program sources.

2. Program Direction

As is the case with the condom, distribution of oral contraceptives through the program is being de-emphasized. The government is making effects to increase the private sector's share of this market.

C. IUD

1. Present Status

The IUD is the most popular method furnished by the government program. About 45 percent of all program acceptors use this method. The IUD is not widely used by people obtaining contraception from private sources. Less than 1 percent of self-supporting acceptors

rely on the IUD. The major reason for this discrepancy is the fact that it is almost impossible for private physicians who are not participating in the designated doctor program to obrain IUDs. IUD's are inserted mainly at designated hospitals and clinics and at health centers. Mobile vans account for about 10 percent of all insertions in rural areas and about 5 percent of all insertions in urban areas. IUD's are available free of charge through the program at 1,677 clinics and hospitals.

The 12 month continuation rate for the IUD is 66 percent, a figure considered unsatisfactorily low by program personnel.

2. Program Direction

Despite suggestions to increase the availability of the IUD to private physicians, the near future is unlikely to witness any major change in policy affecting the status of the IUD.

D. Vasectomy

1. Present Status

It is estimated that approximately equal numbers of vasectomies have been performed in the program and private sectors. In recent years the number of acceptors of this method has gradually increased. During the period 1962-1973 an average of less than 19,000 vasectomies per year were performed by the program. During 1974-1977 this increased to an average of about 43,000 per year. In 1977 almost 54,000 were performed, about 6,000 less than originally targeted.

Vasectomies are available at 980 designated clinics most of which are located in urban areas.

2. Program Direction

Continuing modest yearly increases in vasectomy acceptors are anticipated. Therefore, the relative importance of this method will most likely remain unchanged for the next few years.

E. Female Sterilization

1. Present Status

Korea is experiencing a female sterilization boom. The number of operations jumped from 35,000 in 1976 to over 181,000 in 1977. The 1978 target was originally 160,000 sterilizations but by the end of the first quarter some counties already reported 100 percent achievement. Consequently the target was raised by an additional 90,000 acceptors.

The factors immediately responsible for the jump include increasing the physician's payment from 5,000 to 15,000 won and the increased availability of laparascopes (presently there are 313 in Korea). Since most laparascopes are concentrated in urban areas (57 percent in Seoul and Pusan alone), the number of urban acceptors exceeds that of rural acceptors. As with other methods, the number of program acceptors and private patients are approximately equal.

Despite the boom, laparascopes are still underutilized in many public hospitals. It is also felt that complications increase if a physician performs more than 10-15 laparascopies per day.

2. Program Direction

The boom has caused the government to revise its female sterilization targets upward. For the next five years, 1.22 million operations have been targeted. To quote a recent report ".... success or failure in achieving the population growth target depends on the success or failure of the future female sterilization program." ("Acceptor data on female sterilization in Korea," KIFP, 1977))

To increase the availability of female sterilization, government plans for 1979 include placing almost 95 additional scopes in rural areas, and training additional physicians to man them. The boom will probably continue for most of the five year target period because of a basic fact underlying family planning practice in Korea: 80 percent of current users are practicing contraception to terminate fertility.

F. Induced Abortion and Menstrual Regulation

1. Present Status

Korean abortion rates are among the highest in the world and the widespread use of the method is a major factor in the decline of Korean fertility. In 1975, about 500,000 cases of induced abortion occurred in Korea. The popularity of the method has steadily increased, especially among low income and rural women. In 1976, it

was estimated that 38 percent of married women aged 20-49 had experienced at least one abortion.

Most abortions are performed by the private sector. (In 1975 only 5,000 abortions were performed by the national program and only about 20,000 were done in 1977.) The cost of most privately obtained abortions ranges between 20,000-40,000 won. The operations are performed in hospitals, clinics and physician's offices.

The national program provides fee abortions to low income women. In addition to paying for abortions, the national program actively distributes "Menstrual Regulation (M.R.) kits" to designated doctors, clinics and hospitals.

2. Program Direction

In 1978, the national program increased the number of abortions it performs to 50,000, and the distribution of M.R. Kits was also increased. It is likely that increases in government supported abortion will continue to take place beyond 1978.

It would, however, be a mistake to believe that these increases are being undertaken eightly. Despite the prevalence of abortion, many Koreans are reluctant to see the national family planning program provide abortions. The issue of supplying M.R. Kits to designated clinics was debated in the national assembly. Many feel that abortion should be discouraged in favor of contraception. Many fear negative health outcomes from the large number of repeat abortions done,

and a project soon to be underway will investigate possible negative health impacts from abortion including Salpingitis and Ectopic pregnancy. Such reservations about abortion have been a major reason why 100 percent of abortion coupons, rather than a sample, have been analysed by KIFP.

Figure 2. Trends in the relative importance of methods distributed by the Korean national family planning program 1979-84

	Change in relative inportance
Condom	-
Pill	-
IUD	0
Vasectomy	0
Female sterilization	+
Menstrual regulation (induced abortion)	+

Key : - means that the method will be de-emphasized.
+ means that the method will receive increased emphasis.
0 means no change in emphasis anticipated.

VI. Major Program Problems

In the course of the systems analysis, an attempt was made to determine the major problems faced by the family planning program. It was hoped that this analysis would reveal some problems whose solutions could be facilitated by information provided by the M.I.S. Many external and programmatic problems were considered during the analysis. Four problems were identified that could be influenced by a management information system including the management of special projects, planning for target setting, supervision and acceptor follow-up.

A. Special Project Management. In the absence of a planning process oriented towards identifing program components and evaluating their results and their costs, there has been little attention to the management of individual sub-programs or projects. Major special projects include the UNFPA-funded IE&C program, Hospital project, and Urban Slum project. Without a conscious attempt to monitor each of these programs properly, major wastage of resources is likely to occur, yet a prototype project management system has yet to be developed.

B. Planning for Target Setting. The task of translating program goals into targets for specific activities is still at a rudimentary stage in Korea. Although an attempt is made to translate the overall demographic goals into an estimate of the "births that must be prevented," the leap from there to the activities which will do the job is still enormous.

At the beginning of each calender year the national family planning program decides how many new acceptors of each contraceptive method (condoms, pills, IUD, sterilization) must be recruited during the coming year. Factors considered in the target setting include nation-wide fertility goals, budget allocations, and proposed targets submitted by the provincial governments. The final target is set by the Korean Institute for Family Planning in conjunction with the Ministry of Health and Social Affairs and the Economic Planning Board. These figures may be modified during the year in response to actual demand (upward where demand is high, downward where the demand is low).

Once the numerical targets have been set at the national level, they are apportioned among the provinces; at the provincial level the quotas are divided among the counties and urban words so that each health center receives its own quota for each program method. The health center director assigns a portion of the targets to each fieldworker. The primary criterion used in the distribution of the targets is the size of the eligible population (married women aged 20-44), although at the county level the targets may be adjusted somewhat to reflect the previous year's performance. Thus a health center that had exceeded its target the year before might receive a slightly higher target while the target of another health center with substandard performance might be adjusted downward. During the years

1972-1974, the total yearly targets (all methods combined) amounted to approximately 20 percent of the eligible population.

The 1972-1974 targets have been correlated with the size of the eligible populations in the rural counties. The correlations between the targets for individual methods and the size of the eligible population Ranged from .65 to .90; over 80 percent of the correlations were .85 or higher. This is a clear indication that size of eligible population rather than information about other aspects of the population or about local program characteristics governs the setting of targets.

C. Supervision. The central supervisory team consists of staff personnel from the Ministry of Health and Social Affairs, the Korean Institute for Family Planning, and the Planned Parenthood Federation of Korea. The family planning system includes family planning supervisory staff in each of the provincial capitals and the two special cities, Seoul and Pusan. This staff typically consists of a FP Subsection Chief in the Public Health Section, a small supporting staff, two supervisory nurses, and the medical team responsible for the Province's Mobile Units. At the health center level, there is at least one senior FP worker, who functions in a supervisory/administrative capacity. These personnel are crucial to the effectiveness of the program, as the only regular communication link between the central government and the field, other than the formal reports and occasional

field trip by the central staff. However, no effective way has been found to fully utilize these personnel. The nature of the supervisory problem can be summed up quite succinctly; 1) the central supervisory team is inactive, 2) the provincial and county supervisors have not been trained in supervision, 3) there are no supervisory forms. Thus there is no accountability for supervision, 4) there is no manual of supervision nor formal or informal supervisory proceedures.

Relevant personnel in the family planning program were asked about supervisory practices as part of the mail survey. It was found that supervisory activities are conducted by provincial supervising nurses, health center sub-section chiefs and health center senior workers. Table 1 reveals the main supervisory styles of these personnel. Routine supervision is the most common style, followed by an opportunistic style (a provincial supervising nurse, for example, may pay a supervisory visit to a local health center if she happens to be visiting in the area for some other purpose) and by non-supervision.

Routine supervision is not an efficient use of limited time and opportunstic supervision or failure to supervise at all are not an effective ways of dealing with problems.

Table 2 shows the subjects of the supervisory visits. Broadly, they full into two groups; fieldworker activities and managerial activities.

Table 1. Supervisory methods by position of supervisor

Method	Supervisor's Position					
	Provincial Supervising Nurse		Health Center FP Sub-Section Chief		Health Center Senior Worker	
	Number	Percent	Number	Percent	Number	Percent
1. Routine supervisionof all units according to a pre-established plan	10	59	54	46	100	60
2. Regular supervision of problem areas only	-	-	6	5	21	13
3. Irregular supervision of units as the opportunity presents itself	2	12	32	27	30	18
4. Do not supervise at all	5	29	25	21	16	10
Total	17	100	117	99*	167	101

* Does not add up to 100 percent due to rounding error.

Table 2. Items examined or discussed in supervision by position of supervisor

	Supervisor's Position					
	Provincial Supervising Nurse		Health Center FP Sub-Section Chief		Health Center Senior Worker	
	Number	Percent	Number	Percent	Number	Percent
1. Survey of FP target pop.	6	22.2	5	3.5	14	7.8
2. Reasons for poor achievement	10	55.6	34	23.9	49	27.4
3. Workers' activities	11	61.1	72	50.7	89	49.7
4. Administrative capacity	7	38.9	29	20.4	51	28.3
5. Accuracy of reports & records	4	22.2	16	11.3	33	18.4
6. Follow up of acceptors	5	27.8	15	10.6	39	21.8
7. Mgt. of complications	-	-	4	2.8	17	9.5
8. Logistic mgt.	8	44.4	20	14.1	37	20.7
9. Mobile van & urban clinic mgt.	-	-	4	2.8	14	7.8
10. Supervision of FP authorized clinics	6	33.3	9	6.3	13	7.3
11. Mgt. of Mother's Clubs	4	22.2	8	5.6	19	10.6
12. MCH service	-	-	4	2.8	12	6.7
13. Supervision of FP worker	-	-	3	2.1	6	3.4
14. General health services	-	-	5	3.5	8	4.5
15. Mgt. of urban slum clinics	-	-	3	2.1	16	9.0
16. Program mgt. for remote areas	-	-	-	-	6	3.4
17. Budget expenditures	1	5.6	-	-	-	-
18. Others	1	5.6	2	1.4		
Number	18		142		179	

Issues of greatest concern to provincial supervising nurses include poor achievement, the activities of fieldworkers and the administrative practices of lower level managers. Health center subsection chiefs are concerned about workers' activities, the activities of senior workers and reasons for poor target achievement. Senior workers concentrate on fieldworker activities especially acceptor follow up and record keeping and on poor target achievement and logistic management (inventories).

Only a few items were mentioned by more than 20 percent of respondents. This low frequency is partly due to the fact that the question was open ended rather than forced choice. However, it also indicates that there is very little agreement as to the specific activities requiring supervision.

D. Acceptor Follow-up. Data collected from family planning program personnel in the mail survey conducted as part of this study indicate that follow-up is a serious problem. Family planning fieldworkers estimate that only 18 percent of oral pill acceptors are followed up at home and that only 24 percent of IUD acceptors are followed-up at home. Program personnel estimate, however, that about 9 percent of oral pill acceptors and 11 percent of IUD acceptors return to the health center for consultation on side effects. This situation is mainly due to the fact that the family planning program emphasized recruitment of new acceptors to

the exclusion of other activities, including follow-up: there are acceptor targets but not follow-up or revisit targets. Revisit and follow-up data is not included in the reporting system, although space for this information is included on a number of records. The lack of concern with follow-up is probably a major contributory cause to low continuation rates of IUD's and pills in Korea.

VII. The Service Statistics System

The service statistics system contains three types of instruments: records, coupons and reports. The service statistics system provides information for daily work planning and supervision, for payment and for evaluation. It consists of 17 officially designated forms and records and a large number of unofficial forms developed by provincial and county managers. A list of all official forms and types of unofficial forms gathered during the forms and records analysis is given below. As the list indicates, the burden of record keeping and reporting falls heaviest upon the fieldworkers.

Records

Records are used in health sub-centers, health centers, and by designated clinics and doctors. They are kept for local administrative purposes and are not submitted to higher program levels. There are 11 official records. In general, their functions are

1. To help fieldworkers plan their daily activities by recording the addressess and characteristics of acceptors.
2. To record and store data that is transferred to monthly reports.
3. Patient management.

Figure 3. Forms and records used in the Korean national family planning program by level at which the forms is completed

		Forms	Township (field-worker)	Clinic (Doctor)	County (FP Sub-section Chief Senior Worker	Province (FP Section Chief Super-visor
Official Records	1	Family Planning Registration Record	x			
	2	Certificate of Family Planning Registration	x			
	3	Ri and Dong Acceptor Registration List	x			
	4	List of Sterilization and IUD Acceptors	x			
	5	Pill and Condom Supply Record	x			
	6	Health Center Family Planning Progress Record			x	
	7	Saemaeul Family Health Record	x(1)			
	8	Summary Sheet of Saemaeul Family Planning Program Status	x(1)			
	9	Clinical Record for Loop		x		
	10	Clinical Record for Vasectomy		x		
	11	Side-Effects Record		x		
Official Reports	12	Family Planning Coupon	x	x		
	13	Township Monthly Progress Reports	x			
	14	Health Center & Sub-center Monthly Progress Reports	x(2)			
	15	Provincial Monthly Progress Report				x
	16	Designated Clinics List	x	x		x
	17	Fieldworker Registration Card	x		x	x
Unofficial Records (Types)	18	Family Planning Program Evaluation Checklists			x	x
	19	Program Progress Reports	x		x	
	20	Daily Progress Reports			x	
	21	Daily Fieldworker Diari-s	x			
	22	Travel Report Forms			x	
	23	Lists of Eligible Women	x		x(3)	
	24	Mobile Team Activity Reports			x	x(3)
	25	Follow-up Visit Reports for Loop and Sterilization Acceptors			x	

(1) Officially kept by mothers club leader, in practice kept by fieldworker.
(2) Required but not actually kept.
(3) Not clear if actually kept at this level.

The official records contain almost 300 information items many of them needlessly redundant (see Figure 4). In addition to redundant information a large number of items of questionable value are contained in the records. For example, the family planning registration record gathers such data as the names of acceptors' children, and wheather the couple rents or owns their home. The fieldworkers also carry the heaviest record keeping burden of any group of workers in the program, filling out the majority of records. One of the uses often ascribed to records is to provide data for special studies. However, service statistics records are seldom if ever used as a data source for special studies in Korea. Overall, the records are poorly kept and contain many omissions and inaccuracies. Supervisory staff ordinarily does not check the record keeping of fieldworkers.

A content analysis of selected official records is presented below. It indicates considerable redundancy across reports.

Figure 4. Content analysis of selected records and coupon

Item	Record (1) Family Planning Registration Record	(2) Saemaeul Family Health Record	(3) Ri/Dong Acceptor List	(4) List of IUD and Sterilization Acceptors	(5) Pill and Condom Supply Record
F.P. Reg. No.	x	x	x	x	x
F.P. Reg. Date	x	x	x	x	x
Name of Health Center or Sub-center	x				
Name of Recorder		x			
Acceptors Name	x	x	x	x	x
Acceptors Civil ID No.	x	x			
Acceptors Age	x	x			
Birth Date	x	x			
Education	x				
Age at First Marriage	x	x			
Address	x	x			x
Contraceptive History	x				
Date of Last Menstruation	x				
Pregnancy History	x	x			
Reasons for Discontinuation	x				
Name of Clinic Performing operation				x	
Receipts					x
Disbursements					x
Fees					x
No. of Living Children	x	x			
Sex of Children	x				
Names of Children	x				
Children's D.O.B.	x				
Follow-up Record	x				
No. of Induced Abortions		x			
Method Accepted	x				

A brief description of each of the official records is given below.

1. Family Planning Registration Record

Prepared by: Fieldworker

Submitted to: Filed by F. W. for own use

Purpose: Management and Administration: Worker's reference, basic record of contacts with new and old acceptors. Information transferred to monthly report. Also intended to be used for work planning and follow-up.

Frequency: Each case

Quality of Data: Many itmes ignored by fieldworkers because they are not required for reporting or work planning.

Items 34

Blanks 242

Forms and records containing similar information and/or having similar functions:

Saemaul family health record, coupon, Ri and Dong F.P. registration list, list of IUD and sterilization acceptors, pill and condom supply record.

2. Certificate of Family Planning Registration

Prepared by: Fieldworker

Submitted to: Carried by Acceptor

Purpose: (1) Management and administration to identify acceptor for resupply and revisits.

Frequency: Issued to each registrant

Quality of Data: Although required by government regulations, the registration cards seems seldom issued in practice and seldom required for resupply or revisit. (The registration number does not appear on clinical charts).

Items 8

Blanks 35

Forms and records containing similar information and/or having similar function:

Registration numbers also appear on: registration record Ri and Dong F.P. registration list, list of IUD and sterilization acceptors, pill and condom supply record and coupon.

3. Ri and Dong Acceptor Registration List

Prepared by: Fieldworker

Submitted to: Filed at health center in urban areas, and health sub-centers in rural areas.

Purpose : Management and administration, evaluation workers reference for work planning. To provide field workers with data on progress of saemaul F.P. program.

Frequency: Updated periodically according to workers own schedule.

Quality of Data: Assumed to be highly variable, depends on worker's diligence and interest.

Items 5

Blanks 105

Forms and records containing similar information and/or having similar function: Family planning registration record, list of IUD and sterilization acceptors, pill and condom supply record saemaul family health record.

4. List of Sterilization and IUD Acceptors

Prepared by: Fieldworker

Submitted to: Filed in health center in urban areas and in health sub-centers in rural areas.

Purpose:

Frequency: Variable

Quality of Data: Good

Items 8

Blanks 160

Forms and records containing similar information and/or having similar functions: Coupon registration list and records.

5. Pill and Condom Supply Record

Prepared by: Fieldworker

Submitted to: Filed in health center in urban areas, health sub-centers in rural areas.

Purpose: Provides data for monthly report (target achievement data), inventory.

Frequency: Each case

Quality of Data: Falsification of pill and condom resupply was as high as 15 percent before fees were collected for contraceptives. Falsification now though to be considerably less.

Items 8

Blanks 156

Forms and records containing similar information and/or having similar functions:

Names and registration numbers available from several sources

Function similar to registration lists and records and IUD and sterilization acceptors list - data for monthly reporting.

No other record yields information on no. of pill cycles or no. of condoms for monthly report.

6. Health Center Family Planning Progress Record

Prepared by: Fieldworker

Submitted to: Kept at health center/or health sub-center

Purpose: Management and administration to monitor county level target achievement and other family planning activities on a month by month basis.

Frequency: Monthly

Quality of Data: Based on monthly report data and on fieldworker reports. Most items accurate. A few relating to meetings and lectures are questionable newly introduced form.

Items 52

Blanks 676

Forms and records containing similar information and/or similar functions: Monthly reports

7. Saemaul Family Health Record

Prepared by: Mother's Club leader/fieldworker

Submitted to: Kept in village by mother's club leader.

Purpose: To monitor the amount of family planning practice, health insurance coverage and innoculation of children in a village. 1 card kept for each family

Frequency: Updated monthly

Quality of Data: Some items (no. of issues of "Happy Home" read) clearly impossible to keep accurately. Less than 20 percent of mother's clubs keeping record. In these cases fieldworker usually responsible for recording.

Items 39

Blanks 192

Forms and records containing similar information and/or having similar functions:

Family planning registration lists and records, summary sheet of family planning program status by village.

8. Summary Sheet of Saemaul Family Planning Program Status

Prepared by: Fieldworker

Submitted to: Filed at health sub-center

Purpose: (1) Evaluation Family Planning Program at village level. Summarizes family health records.

Frequency: Quarterly update

Quality of Data: Introduced 1978. No indications of quality yet.

Items 29

Blanks 361

Forms and records containing similar information and/or having a similar function: Registration forms and records, family health record

9. Clinical Record for Loop Acceptors

Prepared by: Physician

Submitted to: Clinical files

Purpose: Patient management

Frequency: Each visit

Quality of Data --

Items 60

Blanks 116

Forms and records containing similar information and/or having similar functions: --

10. Clinical Record for Vasectomy

Prepared by: Physician

Submitted to: Medial files

Purpose: Patient management

Frequency: Each visit

Quality of Data: --

Items 39

Blanks 49

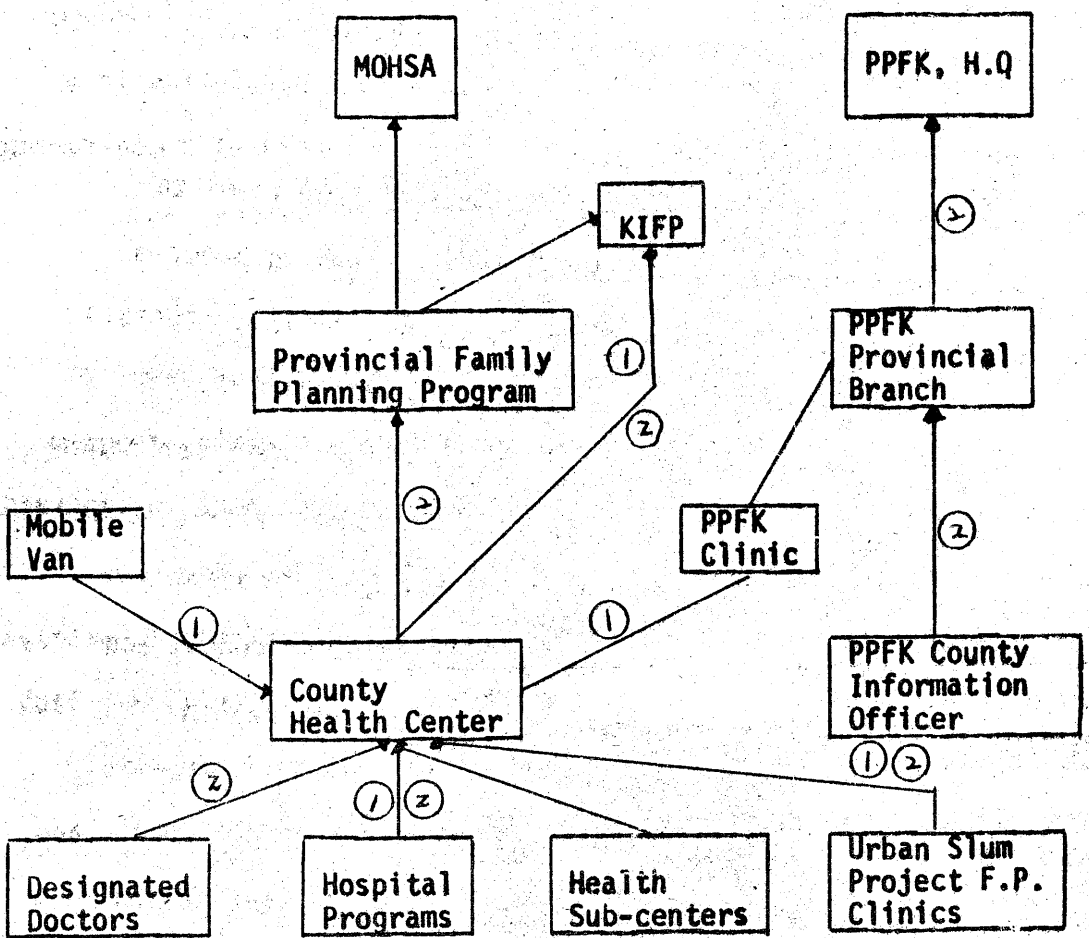
Forms and records containing similar information and/or having similar functions: --

A number of unofficial forms have been designed by provincial and county administrators to augment the official records which focus exclusively on acceptors. The unofficial forms (see Figure 3) range from evaluation checklists to lists of the eligible population in a given area. The greatest number however, are concerned with monitoring the daily activities of fieldworkers, mobile vans, clinics, etc.

Coupon and Reports

Coupons and reports, unlike records, flow upward from level to level. The reporting system of the national family planning program consists of four elements, the family planning coupon, monthly progress reports and reports on the movement of program personnel and the status of designated doctors and clinics. The following chart portrays the reporting system. Notable are the one way information flows, lack of integration between PPFK and the rest of the national program, the lack of a regular reporting channel from KIFP to other boxes, and the merging of special projects data with that of regular health center programs.

Figure 5. The reporting system of the national family planning program



Key : (1) = Coupon.
(2) = Monthly report.

Figure 6 isolates the reporting system of the core agencies of the national family planning program: MOHSA, KIFP and Provincial county and township components.

Figure 6. The national family planning program reporting system: reporting agencies, reports prepared and paper flows

Program Agencies	Reports Prepared	No. of Copies Pre-pared	No. of Copies Sub-mitted	Sub-mitted to	Date of Sub-mission
(1) Township Health Sub-centers (2) FP Centers (urban slum) (3) PPFK Clinic (4) Hospitals with Laparascope Provided by Gov't	FP Program Status Report (Page 3)	2	1	Health Center	1st day of the following month
Health Center	FP Program Status (Page 1-2)	3	2 (Attached each individual reports)	Provincial Gov't KIFP	5th day of the following month
	Coupon	2	1(A)	KIFP	
City and Provincial Government	FP Program Status Report (Page 1-2)	3	2 (With attached HC reports)	M/H&SA KIFP	15th day of the following month

Coupon

The coupon has three functions

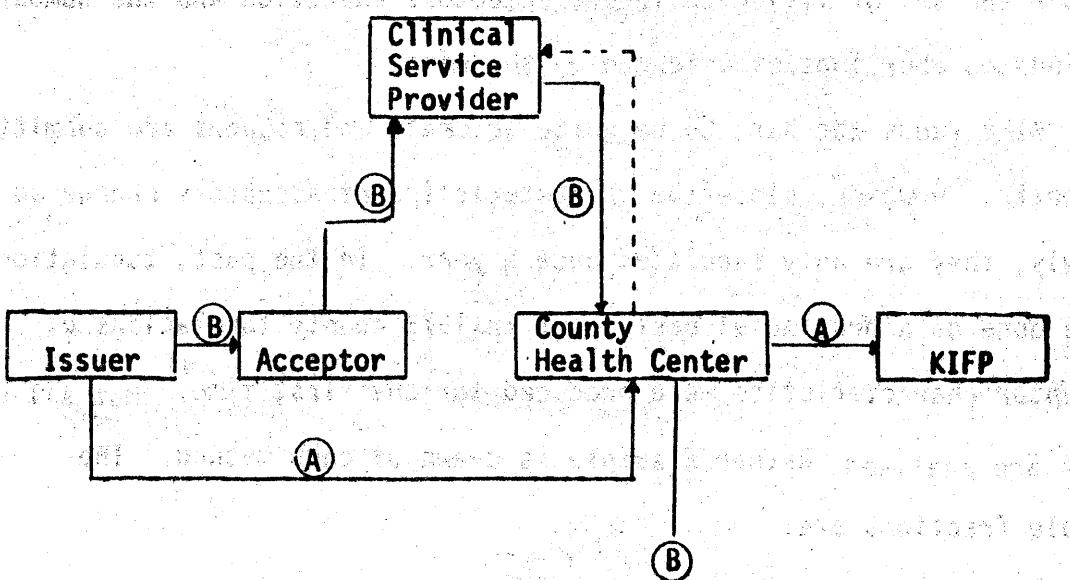
1. It measures progress towards meeting clinical acceptor targets (IUD, Vasectomy, Female Sterilization, Menstrual Regulation).
2. It serves as the service provider's bill to the county health center for contraceptive services rendered.
3. It provides KIFP with information on the demographic characteristics of acceptors.

The family planning coupon is issued to acceptors by a wide variety of family planning and health workers. Officially, it may be issued by health center and sub-center workers, family planning clinic workers, MCH and TB workers, mother's club leaders and PPFK county information and clinic workers. Unofficially, the coupon is also issued by designated physicians and hospital clinics providing family planning services.

The coupon has two parts, part A and part B. Both are partially filled in by the issuer. Part A is sent to the county health center and part B is given to the acceptor for presentation to the service provider who completes the coupon and sends it to the health center payment (of course, if the provider is also the issuer, both parts are sent directly to the health center). The health center pays the provider, matches the coupon halves, files part B and mails part A to KIFP once a month after tabulating the achievement of the issuers. This

process is represented in Figure 7.

Figure 7. The coupon system of the national family planning program



The data contained in the coupon includes the name and registration number and adness of the acceptor and spouse. It also contains the method furnished (IUD first and reinsertion, vasectomy, female sterilization, menstrual regulation). Demographic characteristics of the acceptors obtained through the coupon include the age of the wife, number and sex of living children, acceptors education and the number of induced abortions experienced by the wife.

KIFP funds the data to be quite accurate and coupons are submitted promptly. However, since the characteristics of acceptors change so slowly, they are only tabulated once a year. In the past, tubulations were done on a provincial basis, but in 1977 county tabulations of acceptor characteristics were produced for the first time. Not all coupons are analysed. Rather a sample is drawn of each method. The sample fractions are:

IUD	10 percent
Vasectomy	50 "
Tubal ligation	17 "
Menstrual regulation	100 "

The analysis is limited to the cross tabulation of stati phenomena like the age of acceptors by method.

KIFP uses the data for such purposes as national target setting and computer simulations of the effects of the national program on fertility. Such reports appear inegularly. No attempt has yet been made to study county level variations for managerial purposes, to feedback coupon results, or to alter the contents of the coupon to provide information on problems of current interest. The coupon is described in more detail below.

12. Family Planning Coupon

Prepared by: (1) Fieldworker
(2) Physician

Submitted to: Fieldworker issues to IUD and sterilization acceptors, acceptor presents to physician. Physician completes and submitts to health center for payment. Health center files part B. Submitts part A to KIFP for evaluation purposes.

Purpose: (1) Management and administration and evaluation pay ment of physician
(2) Program evaluation: Number of IUD and sterilization acceptors, acceptors, characreristics.
(3) Target/achievement data.

Frequency: (1) Filed out on a pre-case basis.

(2) Submitted by physicians to health center for payment on a monthly base.

(3) Submitted to KIFP on a monthly base.

Quality of Data: 95 percent of coupons forwarded to KIFP. Over 90 percent of times filled in. Falsification estimated 5 percent.

Items 18/36*

Blanks 18/36*

Forms and records containing similar information and/or having similar functions:

(1) No other forms submitted for payment
Identical information also gathered from frequent surveys.

* The items on part A + B of the coupon are identical.

Monthly Progress Reports

Monthly family planning progress reports are prepared by township health sub-centers, county health centers and provincial units and submitted to the Ministry of Health and Social Affairs (MOHSA) and/or the Korean Institute for Family Planning (KIFP). The purpose of the reports is

1. To inform higher levels of the progress made by lower levels in achieving assigned acceptor targets.
2. To inventory contraceptive supplies for logistics management and to report money collected for pills and condoms distributed.
3. To report personnel levels and vacancies.
4. To keep track of the number of designated physicians active in each township, county and province.
5. To monitor the movement and qualifications of national program staff.

The township, county and provincial progress reports are essentially the same document. The county report is, with only a few additions, an aggregate of the township reports and the provincial report is an aggregate of county data. Consequently, the performance of individual service delivery points such as clinics and township fieldworkers is known only at the county level. The province receives county level

data only and MOHSA receives provincial level data only. KIFP receives both county and township reports but processes only the provincial data. The tabulations are distributed to the KIFP service statistics section and to MOST.

It is possible to obtain the following indicators from the data contained in the monthly reports:

1. Manpower
   - . No. of vacancies by job type or geographic location
   - . Vacancy rates
   - . No. of authorized employees
   - . No. of current employees

2. Registration
   - . Total current registration
   - . Registration increase ratio
   - . Registration dropped rate

3. IUD
   - . No. 1st insertions
   - . No. re-insertions
   - . Total insertions
   - . 1st insertion rate
   - . Period target achievement rate
   - . Cumulative achievement rate

4. Sterilization

   . No. tubal ligation

   . No. vasectomies

   . Period achievement rates

   . Cumulative achievement rates

   . Vasectomy proportions

5. Condom

   . No. of clients

   . Amount of supplies distributed

   . Monthly target achievement rate

6. Oral Contraceptive

   . No. of cycles distributed

   . No. new acceptors

   . No. continuous users

   . Monthly target achievement rate

   . Continuous user proportion

7. Productivity

   . Acceptors/employee ratio

     Target/employee ratio

It must be stressed that the above are derivable indicators rather than indicators that are used regularly. The progress report is especially important as the only source of data on non-clinical methods (condom and pills) distributed by the program. The progress reports yield both the amount of supplies distributed and the number of acceptors. The number of acceptors is, however, unreliable and KIFP calculates the number of pill and condom acceptors by the following formulas:

$$\text{Pill acceptors} = \frac{\text{Total cycles}}{13} \quad (1-W)$$

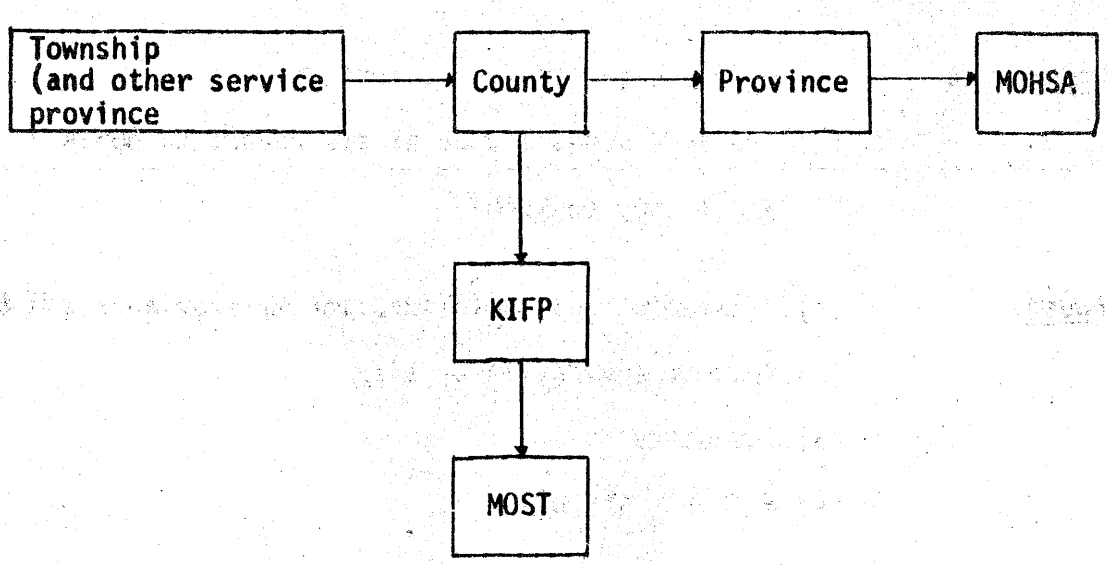
W = wastage

$$\text{Condom acceptors} = \frac{\text{Total packs}}{12} \quad (1-W)$$

W = wastage

Finally, it is necessary to point out that no effort is made at KIFP to combine indicators from the monthly report for management purposes. Also, no attempt to stratify the reporting of health centers and provinces by catagories such as urban-rural, size of target, physicial/pharmacist ratio in the health center area or by other indicator that would allow the classification of units into sub-groups according to factors that might influence performance has been attempted.

Figure 8. Monthly progress reports



13. Family Planning Program Status Report (Monthly Report) Pages 1 & 2

Prepared by: (1) Provincial family planning supervisor
(2) County family planning senior worker

Submitted to: (1) County submitts to province
(2) Province sends 1 copy of its report to MOHSA and 1 copy to KIFP

Purpose: (1) Management and administration by provinces and MOHSA
(2) Program evaluation by KIFP
(3) Inventory
(4) Worker's status

Frequency: Monthly

Quality of Data: Reporting is prompt, virtlally 10090 of all items completed. Information on manpower, abortion, IUD, and sterilization good.

Items 56

Blanks 672

Forms and records containing similar information and/or having similar functions: Coupon, registration list and record. Pill and condom supply record health center progress report.

14. Family Planning Program Status Report (Monthly Report) Page 3

Prepared by: Fieldworkers, PPFK clinics, urban slum area projects, Hospitals with gov't supplied laparascopes.

Submitted to: Health center

Purpose: County and city level management and administration provides basic information for county/province monthly reports, inventory.

Frequency: Monthly

Quality of Data: Same as on pages 1 and 2 (see 9 above)

Items 46

Blanks 46

Forms and records containing similar information and/or having a similar functions: Same as 9 above

Personnel Reports

KIFP maintains a file of all family planning workers. The file contains demographic information and pertinent employment information such as months of experience in family planning, place of current employment, licenses held, position (current and past). Family planning training courses attended, and past target achievement by method. The purposes of the central registration system are,

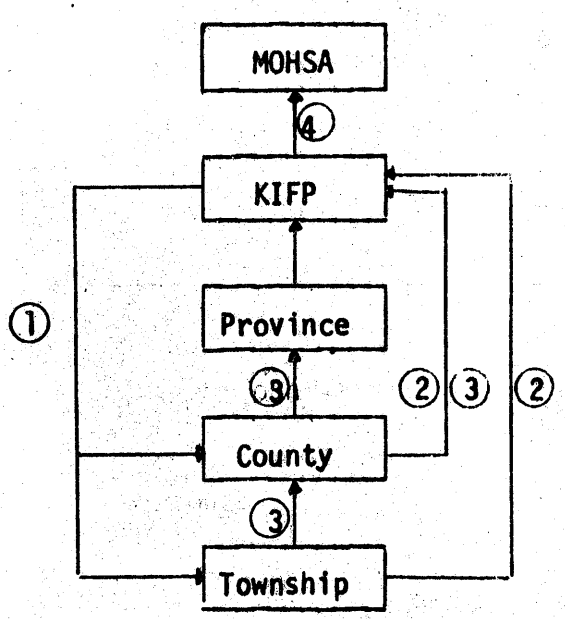
1. To follow the movement of workers.
2. Manpower planning.
3. To locate teaching assistants for the staff training courses.
4. To locate workers in need of training and to help determine the type of training to be given.

This file is updated in two ways. Twice per year in July and January KIFP requests township, county and provincial units to complete a personnel turn-over report that lists all newly employed workers and all workers who have resigned or transferred during the period. A report that updates the qualifications, training and employement history portions of the central files is supposed to be filed by senior workers as notifiable status changes occur. KIFP updates the files and sends a report on status changes to MOHSA.

The files and reports appear to contain a large number of useless items (for example, the workers name is recorded in Chinese characters as well as in Korean and English). In addition, the reports to MOHSA

do not present the information in such a way as to allow manpower planners to identify specific provinces or counties whose workers are poorly trained or qualified or are experiencing unusually high turnover. Finally, although the turnover reports are accurate, the operating units tend to be lax about updating changes in the amount of training received, etc.

Figure 9. Personnel information system



1. Request for vital events record
2. Vital events record
3. Notification of status change

15. Personnel Turnover Report

Prepared by: County and provincial family planning program administrators.

Submitted to: KIFP

Purpose: To monitor personnel movement

Frequency: Twice per year

Quality of Data: Accurate

Items 25

Blanks 75

Forms and records containing similar information and/or having a similar functions: Accurate

16. Personnel Status Change Report

Prepared by: All program staff verified by senior staffs (senior worker, health center director, etc.)

Submitted to: KIFP

Purpose: Manpower planning to monitor the movement and qualifications of national program staff.

Frequency: Twice per year

Quality of Data: Questionable

Items 14

Blanks 58

Forms and records containing similar information and/or having a similar functions:

Clinics

List of Authorized Family Planning Clinics

The purpose of this list is to keep track of the movement of designated physicians into and out of the family planning program. Like all other reports, the information flows upward. A request is passed downward from the Ministry of Health and Social Affairs and eventually reaches the township level. If there is a new designated physician or if a vacancy has occurred, the fieldworker lists the physicians name, address, specialty, and the methods that he is authorized to provide. The report is submitted to the local health center which updates its records and passes the updated versions to the provincial program office which in turr updates its information and submits the revised listings to MOHSA.

17. List of Authorized Family Planning Clinics

Prepared by: Township workers, health center senior workers, provincial supervisors

Submitted to: MOHSA

Purpose: Management and administration to monitor the movement and avilability of designated facilities and methods.

Frequency: Irregular - at request of MOHSA

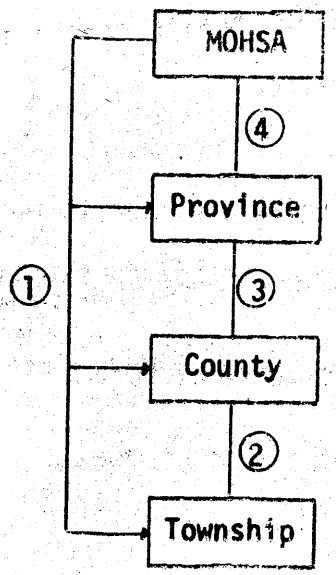
Quality of Data: Accurate

Items 9

Blanks 180

Forms and records containing similar information and/or having similar function: None

Figure 10. Authorized Clinics Information System



① Request for updated authorized clinics list.
② Township list
③ County list
④ Province list

Acceptor Sub-Systems

The foregoing analysis presents a detailed but static view of the service statistics system of the Korean national family planning program. To fully understand the system one must also comprehend the dynamics of the paper flows and see how the mass of records and reports intera-t once the process of recording and reporting is set in motion by a contact between an acceptor and a program worker.

Two flows will be traced. The first is set in motion by an acceptor of a non-clinical method (condoms or pills), the second by an acceptor of a clinical method (IUD, sterilization menstrual regulation).

Acceptors of Non-clinical Methods

Two salient facts emerge about the service statistics sub-system for non-clinical methods.

1. A large amount of data is collected from the acceptors of non-clinical methods. The proceedures are time consuming and disliked by both acceptors and program personnel.
2. Most of the data collected is useless for evaluation and management purposes alike.

To purchase a 30 won ($.06) package of condoms or a 50 won ($.10) cycle of pills a new acceptor must:

a. Provide the fieldworker with 34 times of personal and demographic information including age at marriage and wheather one rents or owns his own home.

b. Be issued a family planning registration card containing 8 items of information to be filled in by the fieldworker and presented each time re-supply is desired.

c. The fieldworker fills out four-five records (depending on area) consisting of

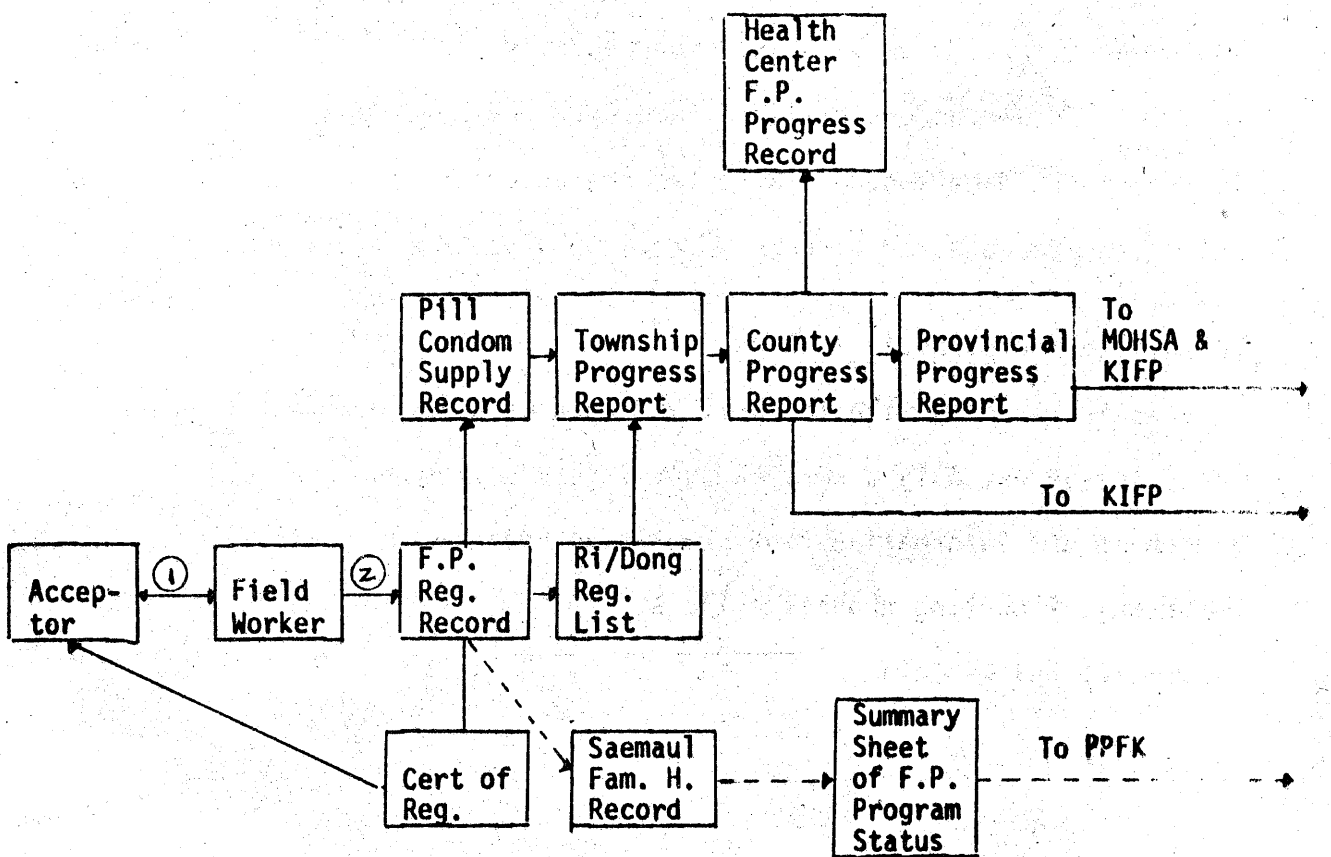
1. Family planning registration record
2. Certificate of family planning program registration
3. Pill/condom supply record
4. Ri/Dong family planning registration list
5. Saemaul family health record (some areas only)

d. Once a month the fieldworker transfers the data from the records to one or two progress reports depending on area.

e. When the condom acceptor returns for re-supply he must furnish the fieldworker with name, address and civil registration number. The fieldworker records this information along with 10 other items on an inventory record.

The process is diagrammed below. It should be noted that the information flows toward KIFP, MOHSA and PPFK contain redundant information, and that the fieldworkers often neglect to issue the certificate of registration and do not record much of the information requested in the records.

Figure 11. Service statistics sub-system for acceptors of non-clinical methods



Key = ① Supplies requested and given

② Paperwork starts

------→ Some areas only

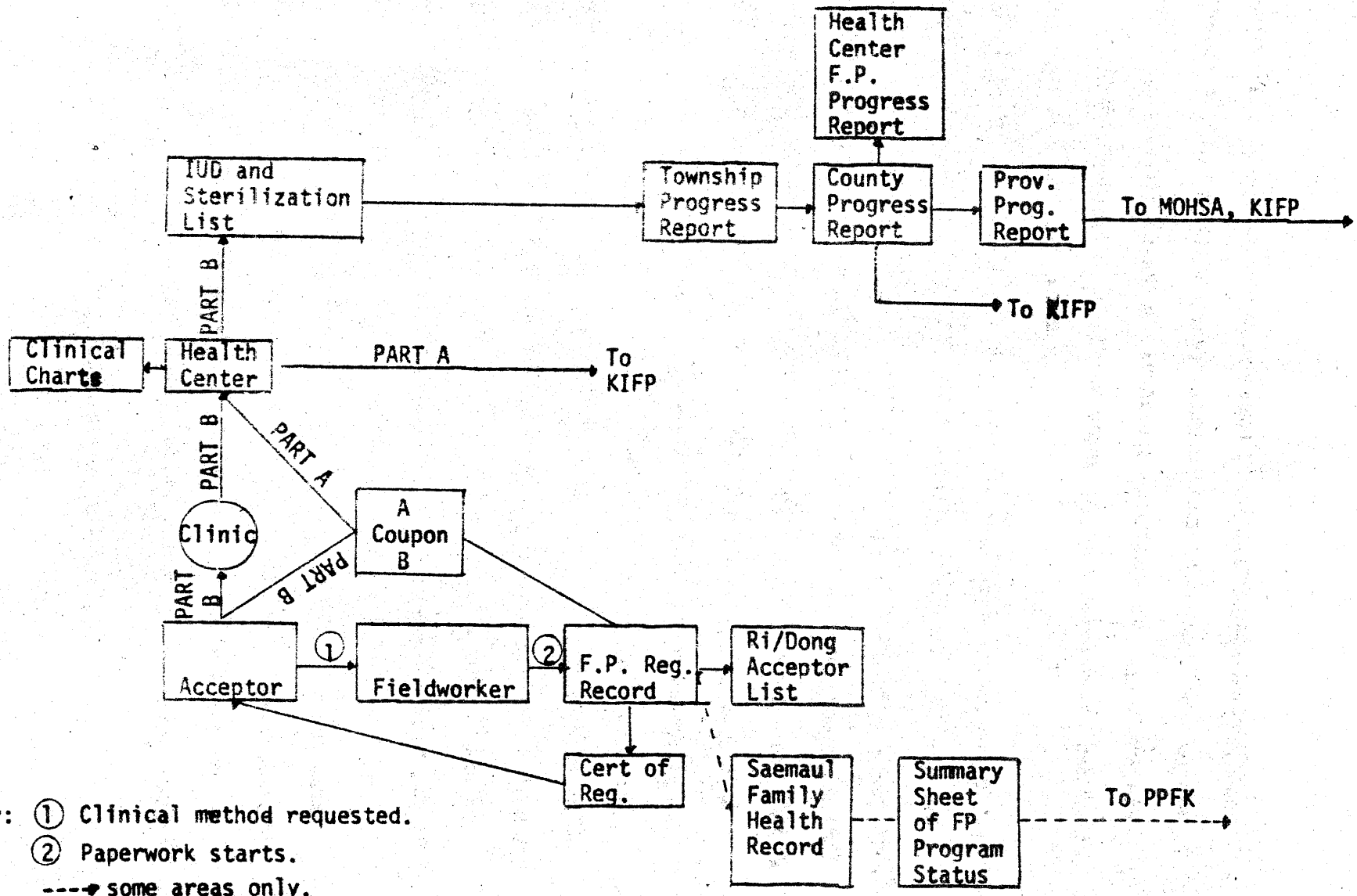
Use of Data Collected

Program evaluators at KIFP have long recognized that data on condom acceptors is unreliable. Consequently, the only service statistics data about condoms utilized in program effectiveness evaluation is the amount distributed. Acceptor characteristics and wastage estimates are gathered through special surveys.

Sub-system for Clinical Methods

As is the case with the pill and condom, a large amount of data is collected but only a small amount is used. The addition of the coupon to the information flow creates an additional, partially redundant, reporting channel. The sub-system for clinical acceptors is charted below.

Figure 12. Service statistics sub-system for clinical acceptors



Key: ① Clinical method requested.
② Paperwork starts.
----→ some areas only.

VIII. Job and Information Use Analysis

A basic step in determining information needs is to discover what people actually do on their job. Consequently, it was decided to review the responsibilities and activities of service delivery personnel and to produce job descriptions for them. Job descriptions were produced for the provincial family planning sub-section chief, the provincial family planning supervising nurse, the health center family planning sub-section chief, the health center family planning senior worker, the PPFK IE&C officer, and the health sub-center family planning worker (fieldworker). The job descriptions which are summarized below and reproduced in their entirety in appendix 3 are an important by-product of the systems analysis because they constitute the first complete set of job descriptions (specifying workers' activities as well as general responsibilities) ever produced for the national family planning program. These job descriptions were compiled from interviews with the relevant personnel. However each job description is necessarily somewhat idealized and it would be a mistake to assume that all the activities and responsibilities listed are actually shouldered by all persons in a given job catagory.

A consideration basic to the design of any information system is the ability of the personnel to utilize information. This ability depends on the education level, training and the job tenure of the users. Low levels of education imply that the system needs to be

very simple, while higher levels of education imply ability to interpret more complex data. Likewise, long job tenure implies a greater potental for actually using information to make program decisions and changes than does short job tenure. Therefore, one section of the mail survey was devoted to questions relating to education, training and job tenure of personnel.

Finally, the survey also examined the current service statistics information use patterns of program personnel at the provincial county and township levels. It was hoped that examination of these patterns would reveal areas of concern to managers and workers and would pinpoint the forms and items which were of greatest and least value to them.

Personnel were asked to indicate, from a list of official forms, which records and reports they actually used. Only those forms used by at least 50 percent of the personnel in a given job category were deemed necessary for discharge of routine job functions. Personnel were also asked to indicate if they found the information contained in the forms "very useful," "somewhat useful," or "not very useful." It was decided to collapse the latter catagories because only a small number of "not very useful," responses were given. The resulting dichotomization, however, still preserves the important distinction between those forms and records that are truly important to job performance and those which merely provide background information.

Finally, the individual items contained in the forms were grouped by type including background and demographic characteristics of acceptors, fertility history and status, logistics, mothers clubs and workers activities, etc. A few representative items were selected from each group and program personnel were asked to rate them according to the degree they were useful in performing daily work activities. The three item scale ranged from "very useful" to "somewhat useful," to "not useful." In the analyses, attention was focused on those items that were rate "very useful" by 50 percent or more of the respondents and on those items rated not useful by at least 20 percent of the respondents.

A. Provincial Family Planning Sub-section Chief has overall responsibility for the performance of the family planning program in his province. This responsibility encompasses program planning, management of personnel and mobile vans, supervision, contraceptive supplies and logistics and reporting. His actual activities concentrate on budgeting, accounting and managing program funds. He also reviews and attests most of the work done by the provincial supervising nurses under his command.

B. Provincial Supervising Nurses Actually carry out most of the activities other than those relating to budgeting and accounting that are carried out at the provincial level. The nurses allocate the provincial targets among the health centers, monitor target achievement,

recruit workers, manage the mobile team, supervise health center middle managers and check on the sanitary conditions of designated facilities.

The results of the mail survey indicate that provincial family planning sub-section chiefs are well educated. Five of the eight respondents had college training and only one had less than a high school education. Unfortunately, the high educational status is undermined by very short job tenure. Half of the respondents had been in their present positions less than one year and many for less than six months. In addition, at time of survey, three of the eleven provincial family planning sub-section chief positions were vacant, and this vacancy rate is usual. Sub-section chiefs are not career family planning workers. Half have less than one year of experience in the field, and none have any family planning training. Finally, the involvement of these workers in the actual daily management of the program is non-existent: they were unable to supply any information about the activities of the family planning sub-section other than their own biographical data.

Table 3. Educational experience of the provincial level personnel

	FP Subsection Chief		Supervising Nurse	
	Number	Percent	Number	Percent
Primary	1	12	-	-
Middle	1	12	1	6
High	1	12	11	61
College	5	62	6	33
Total	8	98*	18	100

* Does not add up to 100 percent due to rounding error.

The educational level of the 18 provincial family planning supervisory nurses is not as high as that of the chiefs but it is still fairly impressive. About one third have had some college training (mostly junior college nursing school). An additional 61 percent are high school graduates. About one third of the nurses have nurses training beyond the high school level. About a third also hold a midwife's certificate in addition to their basic nurses training and about 80 percent have had a family planning training course.

Table 4. Length of time in present job; provincial personnel

	Sub-section Chief		Supervisory Nurse	
	Number	Percent	Number	Percent
1 yr.	4	50	7	41
1-2 yrs.	1	12	3	18
2-3 yrs.	2	24	-	-
3-4 yrs.	-	-	-	-
4-5 yrs.	-	-	1	6
5+ yrs.	1	12	6	35
Total	8	98*	17	100

* Does not add up to 100 percent due to rounding error.

The supervisory nurses also have somewhat longer job tenure than sub-section chiefs. Over 40 percent have more than four years of experience in their present job while half have been in family planning for more than five years.

Table 5. Years of experience in family planning: provincial personnel

	Sub-section Chief		Supervisory Nurse	
	Number	Percent	Number	Percent
1 yr.	3	38	1	6
1-2 yrs.	1	12	2	11
2-3 yrs.	1	12	3	17
3-4 yrs.	-	-	3	17
4-5 yrs.	-	-	-	-
5-6 yrs.	1	12	1	6
6-9 yrs.	2	24	1	6
9+ yrs.	-	-	7	39
Total	8	99*	18	102*

* Does not add up to 100 percent due to rounding error.

Clearly, at the provincial level the supervising nurse is in the best position to use information.

The forms commonly used at the provincial level, and the supervising nurses' overall evaluation of the usefulness of these records is displayed in Table 6.

Table 6. Supervising nurses' evaluation of forms and records used at the provincial level (N=18)

Form	Number/percent using	Very useful	Somewhat/not very useful
1. List of designated clinics	15 (83)	9 (60)	6 (40)
2. Health center monthly report	17 (94)	11 (65)	6 (35)

The listing of designated clinics is a periodic MOHSA requirement presumably, the activity also contributes to maintaining the numbers of family planning physicians at desired levels: It is the duty of the provincial government to request the appointment new physicians from the ministry. The only other form mentioned by the provincial supervising nurses is the monthly health center report. This report forms the basis of the provincial monthly report and in addition provides the province with information on target achievement, inventories and personnel vacancies at the county level.

Provincial supervising nurses' ratings of the data item usefulness are presented in Table 7. An immediate problem was the fact that the nurses did not limit comment to items on forms they used regularly. On the controry, many choose to comment on the usefulness of data items which they never encountered. It was decided to include such seldom or never encountered data items in the results for two reasons (1) they provide an insight into areas of concern (2) they identify items about which these is consensus across job catagories. In Table 7, items contained in forms actually used by the provincial managers are listed above the dotted line, while those items which appear on forms used by others are listed below the dotted line.

Table 7. Rating of data item usefulness by provincial supervising nurses (N=18)

	Very useful items		Not useful items	
	1	2	3	4
	Items scored very useful by more than 70 percent of respondents	Items scored very useful by 50-70 percent of respondents	Items scored not useful by more than 30 percent of respondents	Items scored not useful by 20-30 percent of respondents
A. Items contained on forms used by provincial supervising nurses	1. Monthly manpower status 2. Target achievement 3. Monthly contraceptive 4. Cumulative contraceptive inventories	1. Types of contraceptives supplied acceptors 2. Numbers of loop and sterilization acceptors 3. Names of clinics suppling services	1. No. of FP registrations	
B. Items contained on forms not used by supervising nurses		4. Acceptors age 5. Number of children 6. No. of home visits made by fieldworker 7. No. of visits to health center 8. Contraceptive methods dispenses by designated clinics 9. No. of side effects treated	1. No. of acceptors followed up 2. Type and house inhabited by acceptor 3. Reasons for dropout 4. Monthly pregnancy history 5. No. of acceptors spontaneous abortions 6. Acceptors age at first marriage 7. No. of active mothers clubs 8. No. of group meetings	1. Sex of acceptors children 2. Age of acceptors children 3. Acceptors contraceptive history 4. Reasons for dropout 5. Acceptors age at marriage 6. No. of acceptors spontaneous abortions

Most of the useful items fall into three catagories: (1) target achievement, (2) inventory and logistics, (3) manpower. Those items contained on forms not actually used but still scored "very useful," relate to the daily activities of fieldworkers and to acceptor characteristics. Almost all items scored "not very useful" by the nurses are on forms not used at the provincial level. In general, provincial managers believe that acceptors family characteristics and fertility history are not important. A large number also stated that information about mothers clubs and family planning educational activities was not important to their job performance.

The only item appearing on forms used at the provincial level which was rated not useful was number of family planning registrations. This item is not one of the success criteria by which provincial family planning effort is judged, and it does not relate to specific job activities performed by the nurses.

C. Health Center Sub-section Chief. Personnel at this grade have overall responsibility for the family planning program in the area served by their health center. However, unlike their provincial counterparts they are likely to engage in such activities as target allocation to health sub-centers and fieldworkers, to consult with the PPFK information officer on the local IE&C program, to appoint fieldworkers and recommend designated physicians for appointment.

D. Health Center Family Planning Senior Worker. The senior worker collaborates with the sub-section chief on most of the above activities. In addition she assigns fieldworkers, makes home visiting assignments, plans street campaigns, checks the paperwork and sanitary conditions at designated facilities, is responsible for inventory and storage of supplies, checks fees collected against supplies distributed, and provides direct services to acceptors when necessary.

Educational levels of county level managerial personnel are lower than those of provincial personnel. Among the 142 health center family planning sub-section chiefs, only about 25 percent have some college and another 54 percent have a high school education. Slightly over 22 percent have nursing certificates, most at the high school and junior college levels. Only 2 of the health center sub-section chiefs have had midwife training. Only about half received family planning training. Most of the county level sub-section chiefs have been in their jobs for less than two years, although a sizable minority (about 27 percent) have been in their present position for more than three years. Their total experience in family planning is also fairly short. Over 50 percent have less than two years of experience.

Table 8. Educational experience of county level personnel

	FP Sub-section Chief		Senior Worker	
	Number	Percent	Number	Percent
Primary	2	1	1	1
Middle	27	20	84	48
High	74	54	48	27
College	35	25	42	24
Total	138	100	175	100

The major difference in the educational backgrounds of family planning senior workers and health center family planning sub-section chiefs is that the senior workers are more likely to have only a middle school education and less likely to have a high school education.

Almost two thirds of the senior workers are nurses, but most received their nurses training at the middle and high school levels. About one third have had midwife training. Over 90 percent have had family planning training.

The senior workers have been on the job somewhat longer than the sub-section chiefs, but their real strength lies in their many years of family planning experience. About 52 percent have more than five years experience in family planning

Table 9. Length of time in present job: county workers

	Health center FP sub-section chief		FP senior workers	
	Number	Percent	Number	Percent
1 yr.	48	34	40	24
1-2 yrs.	41	29	23	14
2-3 yrs.	15	11	25	15
3-4 yrs.	8	6	8	5
4-5 yrs.	1	1	7	5
5+ yrs.	28	20	61	37
Total	141	100	164	100

At the county level both the sub-section chiefs and the senior workers stay in their jobs long enough to include in the planning for a management information system. However, given their lower educational attainment the data provided cannot be as complex as at the provincial level.

Table 10. Years of experience in family planning: county workers

	Health center FP sub-section chief		FP senior workers	
	Number	Percent	Number	Percent
1 yr.	37	27	9	6
1-2 yrs.	33	24	18	13
2-3 yrs.	19	14	18	13
3-4 yrs.	15	11	2	1
4-5 yrs.	10	7	6	4
5+ yrs.	23	17	86	62
Total	137	100	139	99*

* Does not add up to 100 percent due to rounding error.

Table 11 shows the evaluation of forms used at the county level by the health center sub-section chiefs and senior workers. Obviously, more forms are used at the county level than at the provincial level. In addition, it is also clear that sub-section chiefs and senior workers use the same forms and records. The first form in Table 12, the family planning registration record, is not filed out by either the sub-section chief or the senior worker. It is their responsibility, however, to teach fieldworkers how to fill it out and to see that it is properly kept and updated.

The usefulness ratings of several forms are quite low, for example the list of designated clinics was rated as "very useful" by only 23-33 percent of the sub-section chiefs and senior workers, respectively.

The usefulness ratings of individual data items are given in Table 12. The small number of ratings of data items contained on forms not used at the county level is a function of the fact that a much larger number of forms is used by the sub-section chiefs and senior workers than is used by provincial managers.

Both sub-section chiefs and senior workers found success criteria such as target achievement very important. They also agreed on the usefulness of items that related to such daily responsibilities as contraceptive inventories and payment of fees. Senior workers also expressed some interest in items reflecting worker's daily activities and acceptor characteristics.

Items of family background like to type of house an acceptor lives in and her age at marriage were rated as not useful by the county managers.

E. Fieldworkers. These workers operate in rural townships and urban neighborhoods. They visit eligible couples, deliver pills and condoms, issue coupons and assist and guide mother's club leaders, especially in record keeping.

Township and urban neighborhood workers are mostly high school graduates and either nurses or midwifes. Over 90 percent have had family planning training. Over two thirds have been field workers for more than two years and 53 percent have more than 5 years of experience in the family planning field.

Table 11. Evaluation of forms used at the county level

Form	Sub-section chief (N=142)						Senior worker (N=179)					
	Users		Very useful		Somewhat/not very useful		Users		Very useful		Somewhat/not very useful	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1. FP registration record	106	75	69	68	32	32	135	75	101	76	32	24
2. FP coupon	110	78	81	76	25	24	150	84	124	85	22	15
3. Ri/dong registration list	102	72	51	55	42	45	135	75	77	59	54	41
4. IUD and sterilization acceptor list	107	75	64	62	40	38	149	83	97	67	48	33
5. Contraceptive supply record	108	76	60	58	43	42	153	86	90	61	57	39
6. IUD clinical record	102	72	49	51	48	49	155	87	65	47	72	53
7. Sterilization clinical record	92	65	42	48	46	52	130	73	78	56	62	44
8. List of designated FP clinics	75	53	23	33	47	67	100	56	33	36	59	64
9. Application forms for designated clinics	79	56	26	37	45	63	107	60	43	40	64	60
10. Health center monthly report	89	63	55	67	27	33	115	64	88	71	36	29
11. Health sub-center level monthly report	106	75	69	70	29	30	145	81	105	69	47	31

Table 12. Ratings of data item usefulness by health center sub-section chiefs and senior workers

Very useful items				Not useful items			
1		2		1		2	
Items scored very useful by more than 70 percent of respondents		Items scored very useful by 50-70 percent of respondents		Items scored very useful by more than 70 percent respondents		Items scored very useful by 50-70 percent of respondents	
Sub-section chiefs (N=142)	Senior worker (N=179)	Sub-section chiefs (N=142)	Senior workers (N=179)	Sub-section chiefs (N=142)	Senior worker (N=179)	Sub-section chiefs (N=142)	Senior workers (N=179)
	1. Target achievement 2. Cumulative contraceptive inventory 3. Monthly contraceptive inventory 4. No. of loop and sterilization acceptors 5. Contraceptives supplied to acceptors	1. Target achievement 2. Cumulative contraceptive inventory 3. Monthly contraceptive inventory 4. Names and dates of clinics providing services 5. No. of loop and sterilization acceptors 6. No. of registration	1. No. of registration 2. Supply fees 3. Names and dates of clinics providing services 4. Name of worker recruiting acceptor				
			5. No. of acceptors followed up 6. Acceptor's civil registration number 7. Acceptors age 8. Acceptors no. of children		1. Type of house acceptor resides in	1. Type of house acceptor resides in 2. Acceptors age at marriage	

Table 13. Educational experience of the township workers

	Number	Percent
Primary	-	-
Middle	41	26
High	104	66
College	13	8
Total	158	100

Table 14. Township and urban neighborhood workers: years in present job and years in family planning

	Years in present job		Years in family planning	
	Number	Percent	Number	Percent
1 yr.	20	13	11	8
1-2 yrs.	22	15	11	8
2-3 yrs.	15	10	17	12
3-4 yrs.	16	11	20	14
4-5 yrs.	19	13	9	6
5+ yrs.	58	39	76	53
Total	150	101*	144	101*

* Does not add up to 100 percent due to rounding error.

Urban and rural fieldworker ratings of record use are given in Table 15.

Table 15. Fieldworkers' evaluation of forms used (N=158)

Forms	Number/percent using	Very useful	Somewhat/not very useful
1. FP registration record	150 (95)	95 (64)	53 (36)
2. FP coupon	150 (95)	112 (77)	34 (23)
3. Ri/dong registration list	145 (92)	73 (70)	32 (30)
4. Loop and sterilization acceptor list	150 (95)	88 (60)	59 (40)
5. Contraceptive supply record	138 (87)	89 (65)	48 (35)
6. Health sub-center monthly report	113 (72)	85 (82)	19 (18)

The monthly report is rated very useful by fieldworkers more often than any other form used. This is probably because the performance of the field workers is judged on the basis of the results contained in the monthly report. The forms receiving relatively low (60-70 percent) "very useful" ratings are somewhat redundant in purpose and content.

Fieldworker item ratings are presented in Table 16. Most of the "very useful" items relate to target achievement, inventory and fees. In contrast to other personnel grodes, the fieldworkers area also interested in the acceptor's contraceptive and fertility status. "Not useful" items include side effects treated, acceptor family characteristics and mothers clubs activities (some of the apparent lack of interest in mothers clubs must be attributed to the fact that they are not active in urban areas or in all rural areas).

Table 16. Rating of data item usefulness by fieldworkers (N=158)

Very useful items		Not useful items	
1 Items scored very useful by more than 70 percent of respondents	2 Items scored very useful by 50-70 percent of respondents	1 Items scored not useful by more than 30 percent of respondents	2 Items scored not useful by 20-30 percent of respondents
1. Acceptors; sex, age, no. of children	1. Acceptors menstrual status	1. Acceptors no. of induced abortions	1. No. of active mothers clubs
2. Contraceptive supplied to acceptors	2. Acceptors contraceptives history	2. Age at marriage	2. No. of spontaneous abortion and still births
3. No. of registration	3. Acceptors pregnancy history	3. Type of house acceptor resides in	
4. Cumulative contraceptive inventory	4. Fees collected	4. No. of side effects treated	
5. Monthly contraceptive inventory	5. Target achievement		
	6. Number of sterilization and loop acceptors		
	7. Names of clinics and dates service provided		

F. PPFK IE&C Officer. These workers were not included among respondents to the mail survey because conducting an analysis of the PPFK service statistics system was beyond the original scope of this project. However, once the degree of interaction between national program workers and PPFK activities was determined it was decided to include the IE&C officers among the job descriptions.

The officers advise mother's clubs, broadcast F.P. spots over village loudspeaker systems, address meetings, show family planning movies, collect PPFK membership fees and make bundle deliveries of Happy Home, the PPFK magazine, to mother's clubs, etc. In addition, they make quarterly tabulations of family health record items and are responsible for considerable record keeping, including a monthly progress and budget report.

Additional Information Desired

Personnel were given the opportunity to state the type of additional information they would most like to receive on a routine basis. Almost no respondents answered this question, and the information items and types and types mentioned were acattered across a multitude of categories. The response to this question reinforces our initial assumption that managers do not seek out information to make routine decisions and are unable to predict what information might be useful in making non-routine decisions.

IX. Responsibilities of Central Level Program Components

This section examines the functions of central level components of the national family planning program including the Ministry of Health and Social Affairs Family Planning Section, the Korean Institute for Family Planning and the Planned Parenthood Federation of Korea IE&C Division and Field Division. It was decided to outline the responsibilities of the various sections rather than to produce job descriptions of key personnel within the components after it was discovered that job descriptions did not clarify the functions of the unit sufficiently. In addition, it was not possible to examine specific activities of the central level program components because a lack of manpwoer curtailed the interviews and observations originally planned to tkae place at these components.

A. Ministry of Health and Social Affairs. The major responsibilities of the Ministry of Health and Social Affairs Family Planning Section include:

1. Overall program planning; target setting and budgeting
2. Personnel management
3. Administrative and technical supervision
4. Maintenance of individual projects
5. logistics and supplies
6. Coordination with concerned organizations.

The Family Planning Section at MOHSA relies heavily on provincial level monthly reports and reports about the number of designated physicians for their monitoring and, to a certain extent, for planning.

B. Korean Institute for Family Planning. No single section at the Korean Institute for Family Planning has been singled out for discussion because all sections make use of service statistics at various times. The major responsibilities of KIFP include:

1. Target setting and projection
2. Long-term and short-term planning
3. Measures of program progress and program evaluation
4. Provision of training to program personnel (workers, physicians, administrators)
5. Basic and applied research for program development and improvement
6. Provision of technical guidance to health centers
7. Development and publication of materials on family planning including periodicals and special reports.

The service statistics essential to carrying out these functions include only a yearly tabulation of acceptor characteristics and number and an up to data central registration record for fieldworkers. The M.I.S. must therefore insure that these basic information needs continue to be met.

C. Planned Parenthood Federation of Korea. The major responsibilities of the Planned Parenthood Federation of Korea include:

1. Provision of IE&C activities
2. Provision of contraceptive services through it's branch clinics
3. Operation of Mothers' clubs
4. Provision of follow-up services for serious medical complications, and
5. Coordination with voluntary organizations.

At present, no routine reporting of IE&C efforts to health centers takes place.

X. Recommendations

This section presents recommendations for the design of a management information system for the Korean National Family Planning Program. These recommendations are based on the findings of the preceding analyses, and the following principles.

1. The system should be as simple as possible. It should be easy to use, and it should pose no more than routine data processing problems.
2. The system should be easily altered. It should be possible to add and subtract records, reports and indicators without making major changes in other records and reports.
3. The system should be relatively inexpensive to operate both in personnel time and money.
4. An overload of information should be avoided. The number and length of reports should be kept to a minimum.
5. The indicators in the system must be valid and reliable and should describe actionable events.

The present service statistics system contains several features that should be preserved. The monthly reports are fairly simple and provide up-to-date effectiveness indicators in the form of target achievement information. The service statistics system seems to handle logistics well. The coupon is a good instrument for reimbursing

physicians' services and for monitoring payment. The coupon also provides KIFP with essential data on the characteristics of acceptors of clinical methods. In addition, the fieldworker registration system and the system for keeping track of the number and location of designated doctors are very useful and also have good potential for providing even more information for management decision making. Finally, the upward step by step flow of reports is a necessary prerequisite for supervision.

On the other hand, there are a large number of weaknesses in the system that need to be corrected. Input data is almost totally absent from the regular reports. The quality of service cannot be monitored routinely. The system is largely irrelevent to such fundamental program tasks as supervision. Service delivery personnel are forced to keep a large number of redundant and useless records and acceptor of non-clinical methods are required to furnish needlessly large amounts of personal information. The following recommendations are made for the solution of these problems.

A. Inputs. To fulfill the goal of producing a more management-oriented information system, the national family planning program must monitor inputs. By themselves inputs provide data on the program's capacity to deliver service. When inputs are used as denominators in conjunction with output numerators, they make efficiency evaluation possible. The

following input data should be considered for inclusion in the new system:

1. Budgets and expenditures at the provincial and/or county level.
2. Number of workers, person-months worked, training and qualifications of workers.
3. Volume and emphasis of IE&C activity at the provincial and/or county level.
4. Number of designated doctors and clinics at the provincial and or county level, and the family planning services they are authorized to provide.
5. Number of active mother's clubs.
6. Number of special project facilities.

Since the role of mobile vans is no longer clear-out and since the importance of the vans as a method of service delivery has degenerated it is not necessary to devise indicators for the measurement of this input.

The highest priority during the next phase of devising the M.I.S. should be to study the feasability of adding cost data to the system. The large and confusing array of background costs which must be dealt with when conducting a formal cost effectiveness study need not be considered. For the purpose of monitoring the efficiency of provincial and county units, an estimate of costs accrued at these levels will

probably suffice, assuming that the same methods of estimation are used for all units. The other input data are readily available and require no additional research to obtain.

B. Outputs. Trends in the importance of methods can and should be reflected in a management information system. It is appropriate, for example, to collect less information about pill and condom users and more information about menstrual regulation.

The reporting system for pills and condoms carries a minimal amount of information about these methods. This should not be changed. On the other hand, dispensing pills and condoms still generates a large amount of useless record keeping at the health center and township levels. This record keeping should be reduced.

Induced abortion is an inefficient method of birth control. One abortion always averts fewer than one birth, in Korea, one abortion may avert as little as one third of a birth. In addition, there is concern over the health consequences of repeated induced abortions. Good medical practice dictates that abortion patients be provided with immediate post-abortal contraception. When contraception is added to abortion, the number of births averted by the abortion increases substantially and the risk of repeat abortions is reduced (at present, for example, it is estimated that one sterilization in Korea averts almost one abortion). Several studies indicate that immediate post-abortion IUD insertion and sterilization are not only safe but also

easily performed.

Therefore it is suggested that:

(1) Abortion coupons should be monitored by KIFP for the health center level at least twice per year.

(2) The purpose fo the monitoring should be to determine the proportion of abortion acceptors who also acceptoimmediate contraception. The program should strive to attain an ideal post-abortal contraception acceptor nate of 100 percent.

(3) Health centers should be informed when the designated doctors in their areas are furnishing an unacceptably low number of aborters with immediate contraception and such health centers should be asked to contact the physicians responsible to improve the situation.

The large number of female sterilizations now being performed by the national family planning program precludes routine monitoring of coupons at the health center level. On the other hand, it is feasable to produce frequent utilization estimates at the health center level. The level of utilization of laparascopes in a health center area could be obtained from the indicator:

$$\frac{\text{No. of tubal ligations}}{\text{No. of laparoscopes}}$$

The number of tubal ligations could be obtained from the monthly report and the number of laparoscopes could be obtained from MOHSA or from the Health Center directly. The average daily number of insertion per operator could also be easily derived from the same sources.

Finally, individual method achievement is reported in the present service statistics system but the overall achievement of a unit is not summarized. Thus, it is impossible to compare the output of a health center with a large pill target but a small IUD target to that of a health center with a small pill target but a large IUD target. The lack of a summary output indicator also is a major barrier to monitoring program efficiency. Therefore, output should be expressed in terms of couple years of protection (CYP) in addition to the present form.

C. Major Program Problems. We have identified four major program problems amendable to solution by information provided by an M.I.S. These problems include target setting, lack of follow-up, lack of supervision and special project management.

Although there is a need to base target levels on some factor other than size of the eligible population, it is not clear what that criterian should be some provincial and county managers use such indicators as population density and number of designated physicians in allocating targets. However, the strength and direction of any relationship between such variables and acceptance is unknown and it would be dangerous to base the allocation of targets on unproven data.

Therefore, it is advised that no attempt be made to include data which are merely assumed useful for target setting in the M.I.S. Rather, it is recommended that a research project be undertaken to investigate actual predictors of program achievement.

Lack of follow-up can only be corrected by a policy decision shifting program emphasis from quantity of acceptors to quality of practice. In the event that such a decision is made, it would be appropriate to include revisit and follow-up information in the monthly reports. In the absence of such a decision, follow-up data would only add to the record keeping burden of fieldworkers and would generate information that was not utilized at higher levels. Secondly, revisit data would have to be recorded by and collected from the designated physicians. Thus, the creation of an information sub-system capabable of providing valid revisit data would be a costly and problemmatic undertaking.

The problem of supervision can be alleviated by the adoption of an M.I.S. Several supervisory systems have been developed which are based on the use of routine management information. Indeed, one of these systems, management by exception, has already been adapted to be used with service statistics data (see Wishik, Samuel M. and Talwar, Prem P., Guidelines for Selective Supervision of Local Service Units in Family Planning Programs, (Manual No. 9, Center for Population and Family Health, Columbia University, 1976).

Application of the M.I.S. to supervisory problems would require no policy decisions, nor any prior research effort. All that would be necessary would be to teach program managers how to use the data provided them in supervising their local programs. Therefore, it is strongly recommended that the Management Information System be formally tied to a system of selective supervision.

The principle of selective supervision is very simple and the system could be easily grasped and used by Korean program workers. In selective supervision, units are assigned priorities for supervision according to their needs, which would be expected to vary among the units within the jurisdiction of any particular supervisor. This principle, is defined as "a system of identification and communication that signals the manager when his attention is needed; conversely, it remains silent when his attention is not needed." Some units warrant closer supervision because of immediate pressing problems or because one of their particular problems is also important to the rest of the program. For instance,a designated clinic to which a large proportion of clients start coming back for IUD removal requires immediate investigation. Similarly, an area with poor program acceptance warrants a fact-finding visit. Both situations have implications for other parts of the program. Such "signaled" units should receive precedence for supervisory visits over those that show average work activity and nothing out of the ordinary.

Most of the information for deciding relative needs of the units for supervision can be obtained from routine family planning statistical reports of individual units. From the service reports, the units given higher priority are those:

(1) which show very low performance,

(2) which show very high performance, or

(3) which have provided insufficient, inconsistent or bizarre statistical data.

Thus, those units which seem to have greater need and where the visits may promise to have greater value for the program would be visited on a priority basis. The other units are visited less often in that period. The decision to visit or not to visit a unit will be based on such considerations as the time needed for a personal visit and the likely value of such a visit, as well as the availability of other means of communication.

Units not contacted during a given time period should receive regular reports of their family planning work, in which their work is compared with that of similar units.

Middle managers will have to be trained in the principles of selective supervision. The M.I.S. will have to contain indicators suitable for use in supervision and it will be necessary to develop supervisory reports, forms and manuals for use in the system.

To devise an adequate management system for special projects is beyond the scope of this work. However, a start can be made by including monthly or quarterly output data from special projects in the new system.

D. Service Statistics System

1. Forms and Records. All catagories of items scored "not useful" by at least 20 percent of relevant personnel should be candidates for removal from the forms and records. The number of data items in the forms and records in the new system should be smaller than the number found in the existing system. Special efforts should also be made to limit the information collected from pill and condom acceptors to the following:

(1) name
(2) address
(3) civil registration no. (which incorporates the acceptor's year of birth)
(4) no. of living children
(5) need for home delivery of contraceptives
(6) monthly time line to record resupply
(7) space for a sketch map of route to acceptor's home
(8) date of last menstrual period

Acceptor registration cards should be eliminated. The ri/dong registration and IUD/sterilization acceptor lists should be combined into a single record. The saemaeul family health records need to be examined. If they have no identifiable use, fieldworkers should not be required to assist in their maintanence. If they are in fact useful, the family health record form should be redesigned or combined with other, similar, records kept by fieldworkers.

2. Reports. Registration data should be eliminated from monthly reports. Some of the data now reported by information officers only to PPFK should be regularly submitted to county health centers for inclusion in reports that eventually reach KIFP and MOHSA. Such action would strengthen the ties between PPFK and the rest of the national program and would make monitoring of IE&C inputs at the local level possible.

The Family Planning Section at MOHSA relies heavily on provincial level monthly reports and reports about the number of designated physicians for their monitoring and, to a certain extent, for planning.

The performance of program units should not be reported only by province and health center. Rather, units should be stratified by urban and rural location and by physician-pharmacist ratio. City health centers operate under different constraints than rural health centers, thus it is more meaningful to compare urban to urban to urban performance and rural to rural rather than to make unstratified province to province or health center to health center comparisons.

A second stratification should be made according to the physician-pharmacist ratio of the county or urban ward in which the health center operates. The physician-pharmacist ratio of an area will directly indicate the extent to which sources of family planning, other than the local unit of the national family planning program are available to eligible couples. The physician-pharmacist ratio will indirectly indicate the socio-economic status of an area. Areas with a high ratio will be relatively affluent while areas with a low ratio will be relatively poor. These stratifications can help focus the attention of the planners and top administrators in the following ways:

- From the point of view of reducing fertility, the performance of rural units is more critical than the performance of urban units.
- From a public health point of view, the performance of units in low physician-pharmacist areas is more important than the performance of units in areas with a high physician pharmacist ratio.
- From a cost point of view, urban units will be more efficient than rural units.
- From a manpower-productivity point of view, acceptors may be easier to recruit in low physician-pharmacist areas than in high physician-pharmacist areas.

- From a provision-of-services point of view, it may be easier to recruit a large number of designated physicians and offer a full range of family planning methods in an areas with a high physician-pharmacist ratio than in an area with a low physician pharmacist ratio.

It is not necessary to produce a report of stratified performance of all indication on a monthly basis. Three or four such reports per year will probably be sufficient to meet administrative and monitoring needs.

Reports in a stratified format can be produced at the computer section of KIFP and forwarded to MOHSA. KIFP must also process service statistics information into reports that will be returned to the provinces and health centers on a regular basis. These reports should make it possible to:

1. Allow provincial managers to compare the performance of (a) their province with other provinces (b) the health centers in their province with each other (c) the health centers in their province with other health centers in the same stratum (d) current provincial and health center performance with past provincial and health center performance.
2. Allow health center managers to compare (a) current performance to past performance. (b) the performance of their health center to other health centers in the same strata.

E. Information Needs

1. MOHSA. Considering MOHSA's overall planning and program monitoring responsibilities, the following indicators should be reviewed for inclusion in the reports sent to MOHSA.

Type		
1. Efficiency	1.1	Total CYP/total cost (by strata, province, health center)
	1.2	Total CYP/total worker months (by province, health center)
	1.3	No. of tubal ligation/no. of laparoscopes (by strata, province, health center
	1.4	Total CYP achievement of a special project/no. of service delivery units in that project
2. Effectiveness	2.1	Target achievement by method (by strata, province, health center)
	2.2	Total CYP/total target in CYP (by strata, province, health center)
3. Coverage	3.1	Active mothers clubs/eligible population X constant (by strata, province, health center)
	3.2	No. of designated physicians/eligible population X constant (by strata, province, health center)
	3.3	No. of Dr.s designated to provide a given method/eligible population X constant (by strata, province, health center)

	3.4	Total no. of pamphlets distributed (group meetings addressed)/total eligible population (by province, health center)
	3.5	Fieldworker months/eligible population X constant (by strata, province, health center)
4. Quality	4.1	No. of immediate post abortal contraceptive acceptors/no. of abortions (by strata, province, health center)
	4.2	Avg. no. of tubal ligations per day/ no. of designated operators (by strata, province, health center)
	4.3	Fieldworkers quality index (by strata, province, health center)

Some of the indicators above will not vary enough or will not be based on a large enough number of cases to justify inclusion in a monthly report. These indicators should be included quarterly or bi-yearly. A data file containing information from non-service statistics sources (such as eligible population size in a health center area) will have to be created. At the present time the indicators in the monthly reports must be calculated by the user of the report. This is time consuming, prone to error and likely to discourage use. Therefore all indicators in the reports computer processed at KIFP should contain pre-calculated indicators.

2. KIFP. The service statistics essential to carrying out KIFP evaluation functions include monthly information on number of pills and condoms distributed, IUD's inserted and sterilizations performed, as well as yearly tabulations of acceptor characteristics from the coupons. The training section requires data from the central registration record for fieldworkers. The M.I.S. must therefore insure that these basic information needs continue to be met. Since the KIFP computer section will be responsible for the data processing for the new M.I.S., the Institute will automotically receive copies of any additional reports produced. It is not deemed wise to increase the flow of research data from the program to KIFP because at the present time, no specific use for such data can be identified. The role of KIFP in the M.I.S., however, should hot be limited to the processing of management information. Service statistics can be used to motivate program personnel. High achievers can be identified and rewarded and the methods behind their success can be publicized. The material development section at KIFP publishes a bi-monthly magazine entitled Population Information which is circulated among national family planning program personnel. Basic service data should appear in this journal from time to time. Cases of outstanding effort should be identified through service statistics; the magazine should contact the individuals responsible and feature them and their successful methods in the next issue.

3. PPFK. The investigation of the information needs of PPFK must be concluded before recommendations can be made.

4. Service Delivery Units. At the provincial level only the information needs of the supervising nurses need be considered. They, rather than the provincial sub-section chiefs, should receive training in selective supervision. The performance indicators suggested for distribution to MOHSA can also be used by the nurses to monitor health centers in their jurisdiction. The reports the nurses are to receive from KIFP should rank health centers within provinces as well as stratum. Health center family planning sub-section chiefs and senior workers make use of the same forms and the same items. In planning for the new system they should be considered as a unit. Both should be trained in selective supervision. The same reports that KIFP sends to the provincial level should be sent to the health centers to allow them to compare their performance to that of other centers. It is not advisable for KIFP to attempt to provide health centers with data relating to the performance of individual workers. Rather, the chiefs and senior workers should be taught to use fieldworker reports and records and coupons in selective supervision and should learn to monitor the emphasis and quantity of IE&C activity in their areas to insure that these resources are properly allocated. The greatest amount of local IE&C activity should be concentrated in problem areas and the messages delivered should relate to those problems.

Finally, managers at the provincial and health center levels should be provided with chart kits to plot the progress of their units over time. They should also be provided with Korean language manuals that allow them to correctly translate the English language printouts received from KIFP.

Conclusion

All the recommendations made in this report are within the data processing, training and materials development capabilities of KIFP. Therefore, the successful conclusion of this project is a matter of interest and application rather than a matter of developing new institutional capabilities. The tasks that remain include investigation of the feasability of adding cost data, final selection of indicators, revision of forms, records and reports, creation of computer files and programs, development of training materials and manuals and implementation of training in selective supervision.

The existing information system fulfills research, logistics, payment and target re-allocation functions. The recommended system would preserve all these functions while adding those of supervision and motivation. The proposed system would also greatly enhance the monitoring capability of MOHSA and the provinces, and would strengthen the ties between PPFK and other program elements.

APPENDIX 1

QUESTIONNAIRE ON RECORD AND REPORTING FORMS FOR FAMILY PLANNING PROGRAM

Appendix QUESTIONAIRE ON RECORD AND REPORTING FORMS FOR FAMILY PLANNING PROGRAM

Address of Your Org.	City	District	Street
	Province	City	Town
		County	Township

Official Position

- ☐ 1. Chief of family planning subsection in city or provincial government.
- ☐ 2. City or Provincial FP supervisor.
- ☐ 3. Chief of family planning subsection in health center.
- ☐ 4. Health center FP senior worker.
- ☐ 5. Health center worker (Dong Worker).
- ☐ 6. Township worker.

Name	Date	1978. . .

May, 1978

Korean Institute for Family Planning

I. Respondent's Characteristics

1. How old are you now?
    1. less than 20 years
    2. 20 - 24 years
    3. 25 - 29 years
    4. 30 - 34 years
    5. 35 - 39 years
    6. 40 - 44 years
    7. more than 45 years

2. What is your marital status?
    1. Married
    2. Single

3. What is the highest level school you attended?
    1. Middle school
    2. High school
    3. Nursing training at middle school level
    4. Nursing training at high school level
    5. Nursing school at Junior college
    6. College or more

4. Do you have a nurse or midwife's certificate?

   1. None
   2. Nurse and midwife
   3. Nurse
   4. Nurse aide
   5. Midwife

5. How long have you worked in the family planning field?

   1. less than one year
   2. 1 - 2 years
   3. 2 - 3 years
   4. 3 - 4 years
   5. 4 - 5 years
   6. 5 - 6 years
   7. 6 - 7 years
   8. 7 - 8 years
   9. 8 - 9 years
   10. more than 9 years

5.1. How long have you been in your present position?

   1. less than 6 months
   2. 6 months - 1 year
   3. 1 - 2 years
   4. 2 - 3 years
   5. 3 - 4 years
   6. 4 - 5 years
   7. more than 5 years

6. Have you ever had a family planning training course?

   1. Yes
   2. No (Go to Question 7)

6.1. If yes, how many total weeks of training have you received?

1. 1 - 2 weeks
2. 3 - 4 weeks
3. 5 - 6 weeks
4. 7 - 8 weeks
5. 9 - 10 weeks
6. more than 11 weeks

6.2. Have you ever attended the "Evaluation Training Course on Family Planning Program" which was held in November 1975 under the joint auspices of KIFP and WHO?

1. No
2. Yes

If yes, how useful has the training been in helping you on the job.

1. very useful
2. somewhat useful
3. not very useful

7. If you are a fieldworker how many days per month, on the average, do you spend making home visits?

If you are a family planning subsection chief or senior worker how many days per month do you spend in the field for the purpose of supervision?

1. 0 - 4	4. 15 - 19
2. 5 - 9	5. 20 - 24
3. 10 - 14	6. 25 +

8. On the average, what proportion of your time is spent on the activities listed below:

(Table 1)

Proportion of time spent

Contents of task	Proportion of time spent
1. Office work for contraceptive services and counselling	
2. Field trips for contraceptive services and counselling	
3. Field trips for supervision of workers	
4. Recording and reporting on family planning programme activity.	
5. Support of other programs such as MCH and TB projects	
6. Others (Specify:)	
Total	100%

Example: If you do not engage in an activity at all, write 0% in the space following the activity.

If you spend all of your time on one activity, write 100% in the space following the activity.

Be sure to include any proportion of your time spent in non-family planning activities in "other"

9. Generally, it is difficult for you to provide follow-up for all new acceptors. Of every 100 new loop acceptors in your area, how many would you estimate actually received follow-up? Of these, how many were visited at home? How many came to the health center?

(Table 2)

Number of acceptors served follow-up

	Loop	Vasectomy	Tubal ligation	Oral Pill
1. Number of persons visited H.C. for follow-up services.				
2. Number of persons served follow-up services through your home visiting.				
Total				

9.1 Out of 100 condom Acceptors, how many do you estimate revisit the health center regularly for resupply?
_____ persons.

10. Please describe briefly activities that you feel are most important to doing your present jobs successfully.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

11. The forms listed below are those officially designated for use by the family planning program. In the spaces provided please indicate which forms you use in your office.

    Next, indicate how useful the information on the forms that you use is in helping you do your job.

Name of the Form	Use or Not		Degree of its Usefulness		
	Use	No Use	Very Useful	Somewhat Useful	Not very Useful
1. FP registration record					
2. FP identification card					
3. FP coupon (A & B)					
4. List of FP registrator by Ri or Dong					

Name of the Form	Use or Not		Degree of its Usefulness		
	Use	No Use	Very Useful	Somewhat Useful	Not Very Useful
5. List of Loop and and sterilization acceptor					
6. Record on contraceptive supplies					
7. Clinical record for loop					
8. Clinical record for sterilization					
9. Clinical record for side-effect					
10. FP progress report used in township					
11. List of Designated FP clinics					
12. Application forms for designated FP clinics					
13. Monthly FP progress report used in health centers and provinces.					
14. Monthly FP progress report used in health sub-center					
15. Monthly report on FP worker's status					

12. If your office has developed any forms and records other than those provided by the Government, please list them and indicate how useful they are to you on your job.

Form Name	Degree of Usefulness		
	1. Very Useful	2. Somewhat Useful	3. Not at All Useful
1.			
2.			
3.			
4.			
5.			

Please attach one copy of each form developed by your office to this questionnaire.

13. The forms you are currently using contain many kinds of data. How useful have the following data items actually been to you on your job.

(Table 5)

No.	Data contained in the forms	Degree of its Utilization		
		Very Useful	Somewhat Useful	Not at All Useful
1.	Acceptor's age and educational level			
2.	Acceptor's sex and number of children			
3.	Sex and age of acceptor's children			
4.	Acceptor's contraceptive history			
5.	Menstrual status and last menstrual date			
6.	Acceptor's pregnancy history by month			
7.	Number of acceptor's induced abortions			
8.	Number of acceptor's spontaneous abortions and still births			
9.	Monthly manpower status			
10.	Acceptor's registration			
11.	Contraceptives supplied to acceptors			
12.	Fees collected for contraceptive supplies			
13.	Monthly target achievement			

No.	Data contained in the forms	Degree of its Utilization		
		Very Useful	Somewhat Useful	Not at All Useful
14.	Monthly inventories of contraceptives			
15.	List of loop and sterilization acceptors			
16.	Acceptor's age at first marriage			
17.	Type of house acceptor is living in.			
18.	Date and reasons of dropout			
19.	Name of clinics and date provided FP services.			
20.	Number of home visits and visitors.			
21.	Contraceptive methods dispensed by designated clinics			
22.	Number of mother's clubs.			
23.	Number of group meetings and attendees.			
24.	Contents of clinical record for sterilization			
25.	Contents of clinical record for sterilization			
26.	Number of side effects treated			
27.	Name of worker who recruited acceptor			

No.	Data contained in the forms	Degree of its Utilization		
		Very Useful	Somewhat Useful	Not at All Useful
28.	Follow-up record			
29.	Registration List			
30.	Cumulative Inventory			

13.1 Are there any data items you would like to have that are not available from the forms and records you use? If so,please list the type of item below

1. _____
2. _____
3. _____
4. _____
5. _____

13.2 How much useful, job-related data are provide with by reports from central level offices (MOHSA, PPFK, KIFP).

1. A great deal
2. A small amount
3. None at all

13.3 If you are provided with data by a control office, please describe it in the spaces provided

1. _____
2. _____
3. _____
4. _____
5. _____

14. Please indicate how much you agree or disagree with each of the questions listed below:

	Attitude about each opinion				
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
The same data items appear over and over again on the forms					
Filling out forms interferes with other work					
The forms contain very little useful data					

	Attitude about each opinion				
	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
I don't have enough knowledge to utilize the information in my work					
I use the information in the forms a great deal in my work					

15. What forms do you submit to superior offices?

(Table 7)

Title of the Forms Submited to Superior Office and their Reporting Frequencies

No.	Form Name	Name of Office Reported To.	Reporting Frequency
1.			1 2 3 4
2.			1 2 3 4
3.			1 2 3 4
4.			1 2 3 4
5.			1 2 3 4
6.			1 2 3 4
7.			1 2 3 4

16. Have you ever evaluated the program in your Area?

1. Yes.

2. No.

16.1 If so, how frequently?

1. Whenever needed

2. Once per months

3. Once per two months

4. Once per three months

5. Once per six months

6. Once per year

16.2 If so, what kinds of data did you use in the evaluation?

1. _____

2. _____

3. _____

4. _____

5. _____

17. Do you think that a basic training course on program evaluation is needed by workers at your level

    1. Very much needed
    2. Somewhat needed
    3. Not needed

18. How do you carry out your supervisory tasks?

    1. Regular supervision of all areas according to a pre-established plan regular
    2. Regular supervision of problem areas only
    3. Irregular supervision of problem areas
    4. Do not supervise

19. If you supervise please list some of the things you usually discuss or examine

    1. _____
    2. _____
    3. _____
    4. _____

20. Have you ever used the "check list card form of program status" or a similar locallydeveloped for the area that you are responsible for?

1. Yes

2. No

If you use a locally developed form please attach it to the questionaire

21. How helpful are the data contained in forms submited to you by subordinates for supervision or evaluation

1. Very helpful

2. Somewhat helpful

3. Not very helful

21.1 If there are any specific data items on these forms that you find especially helpful, please list them

1. _____

2. _____

3. _____

4. _____

5. _____

22. Has the Saemall Family Health Record been introduced into your area?

1. No 2. Yes

22.1 If yes, please indicate the recorders and record-holders on the chart below

(Table 8)

Person	Recorder	Record-holder
1. FP field worker		
2. Chief of mother's club		
3. Chief of village or Dong or Sae Ma Eul leader		
4. Other (Specify:_____)		

22.2 If yes how helpful is the "family health record" to the work in your area & now?

1. Very helpful
2. Somewhat helpful
3. Not very helpful

22.3 Do you think that the data collected in the family health record is accurate

1. Yes
2. No

22.3.1 If No, can you list some reasons why the data is not accurate

1. _____
2. _____
3. _____

23. Please use the remaining space for any comments or suggestions you may have about the family planning program reporting system.

APPENDIX 2

SELECTED FORMS AND RECORDS USED IN THE NATIONAL PROGRAM

(Side 1)

FAMILY PLANNING REGISTRATION RECORD

① Registration Number
② Registration Date
③ Health Center
④ Recorder (Seal)

	⑤ Name	⑥ Resident registration number	⑦ Age	⑧ Birth date	⑨ Education	⑩ Age at first marriage	⑪ House
⑫ Wife							Own
⑬ Husband							Rent

⑭ Address: Si / Gun / Ku — Dong / Eup / Myun — St. / Ri — No. (_____ Tong _____ Ban)

1. Number of living children

⑮ No. of living children	Male	Female	Total

⑯ Order	⑰ Name	⑱ Sex	⑲ Age	⑳ Note

2. Contraception history

㉑ Past contraception	No ( )
	Yes ( )
	Loop ( )
	Oral pill ( )
	Condom ( )
	Others ( )

3. Abortion history

㉒ Induced abortion	No ( ) Yes (times)
㉓ Natural abortion	No ( ) Yes (times)
㉔ Stillbirth	No ( ) Yes (times)

4. Menstruation history

㉕ No menses

㉖ first day of the last menses — Month / Day

5. Contraception and Pregnancy history

Year \ Month	1	2	3	4	5	6	7	8	9	10	11	12
㉗ 19 ...												
19 ...												
19 ...												

Year \ Month	1	2	3	4	5	6	7	8	9	10	11	12
19 ...												
19 ...												
19 ...												

6. Termination of registration

㉘ Date: ___year ___mo. ___day

㉙ Reason: 1.moved 2.infecund 3.death 4.menopausal 5.sterilized 6.other

㉚ Termination recorder (seal)

7. Counselling and clinical record

㉛ Year	Month Day	㉜ Contents	㉝F.W. Seal	Year	Month Day	Contents	F.W. Seal

㉞ Sketch map to registrant's home

(Side 1)

CERTIFICATE OF FP REGISTRATION

Registration Number		Registration date	year month day
Name			
Address	Ku Si Gun / Dong Eup Myun / St. Ri / No.		

Health Center
Hospital

(Side 2)

GUIDANCE OR TREATMENT					
Date	Content	Seal	Date	Content	Seal

RI AND DONG FAMILY PLANNING REGISTRATION LIST

① Registration number	② Registration date	③ Name	④ Sex	⑤ Remarks

① Registration No.	FAMILY PLANNING COUPON (A&B)	② Acceptor	Name
			Resident registration number
			Spouses name

③ Address	Si / Do	Si / Ku / Gun	Eup / Myun / Dong	St. / Ri	No.

④ Contraceptive method	*	* 1. Loop insertion 2. Loop reinsertion 3. Vasectomy 4. Female sterilization (laparascopic, mini-lap, others) 5. M.R.	⑤ Physician	Name of clinic
				Date
				Name of physician

⑥ Education	⑦ Woman's Age	Number of living children		Number of induced abortion	Recruitor	Agency
		Male	Female			Name
**						

**
1. No education
2. Primary
3. Middle school
4. High school
5. College or more

This is to certify as indicated in the above

_____year _____month _____day

Director of health center (Seal)

LIST OF STERILIZATION & IUD ACCEPTORS

① Serial Number	② Registration date	③ Registration number	④ Name	⑤ Address	⑥ Date of operation	⑦ Name of clinic	⑧ F.W. Seal

PILL AND CONDOM SUPPLY RECORD

① Person supplied						⑧	⑨ Inventory			⑬
② Serial number	③ Date	④ Registration number	⑤ Name	⑥ Address	⑦ Amount distributed	Fee	⑩ Amount received	⑪ Amount supplied	⑫ Balance	F.W. Seal

Name of region ( )

HEALTH CENTER FAMILY PLANNING PROGRESS RECORD

No. of Eligible Couples in 19____. ____.____.

Classification	Target	Month _____			① Jan	② Feb	③ Mar	④ Apr	⑤ May	⑥ Jun	⑦ Jul	⑧ Aug	⑨ Sep	⑩ Oct	⑪ Nov	⑫ Dec	⑬ Total
Registration	⑭	⑮ New		⑯ Actual													
Loop	⑰	⑱ First Insertion		⑲ Reinsertion after six mos.													
Sterilization	⑳	㉑ Monthly Total		㉒ Cum. Total													
Condom	㉓	㉔ Persons		㉕ Dozens													
Oral Pill	㉖	㉗ No. of side effect treatments															
		Paid	New	㉘ Pers. / ㉙ Cycles													
			Total	㉚ / ㉛													
		Free	New	㉜ / ㉝													
			Total	㉞ / ㉟													
		Total	New	㊱ / ㊲													
			Total	㊳ / ㊴													
		㊵ Fee															
Mother's Club *		㊶ Number		㊷ Number of Members													
Home or Clinic visits		㊸ Home Visits		㊹ Clinic Visits													
Group Education	Lecture	㊺ Number of Lectures		㊻ Number of Attending													
	Discussion Meeting	㊼		㊽													
	Audio Visual Education	㊾		㊿													
	Total																

* Indicate number of organized mother's club

LIST OF AUTHORIZED FAMILY PLANNING CLINICS

Name of Province (or City):

City, County, District	Clinic		③ Authorization Date	④ Name of Physician	⑤ IUD	⑥ Vasectomy	⑦ Female Sterilization	⑧ Physician's Specialization
	① Name	② Location						

SAEMAEUL
FAMILY HEALTH RECORD

① Date of record: 1978...

② Name of recorder:

③ Position:

Reg. No.	④ Si ☐☐	⑤ Gun ☐☐	⑥ Eup/Myun ☐☐	⑦ Ri/Dong ☐☐	⑧ Indiv. No. ☐☐☐
⑨ Address		Eup Myun	Ri Dong	No.	
⑩ Wife's Name		⑪ Civil Reg.No.		⑫ Education	Pri. Midd. Hig. Coll.
Husband's Name		"		"	"
⑬ Duration of marriage	yrs	⑭ Occu.(wife)		⑯ Type of medical insurance	Yel. Green Black
		⑮ Occu.(husb)			

1. Pregnancy & Contraceptive History

	⑰ Monthly Family Planning and Pregnancy Record												⑱ Remarks	⑲ Issues of "Happy Home" read
	1	2	3	4	5	6	7	8	9	10	11	12		
1977														
1978														
1979														
1980														
1981														

Key : P - Pregnancy
V - Vasectomy
R - Rhythm
N - Not using
I - Induced abortion
T - Tubal ligation
O - Other traditional methods
M - Menopausal
S - Spontaneous Abortion
L - Loop C - Condom P - Oral pill

II. Child Health Care

㉑ Child's name	㉒ Sex	㉓ Birth date	Record of Inoculations					㉘ Remarks
			㉔ Vaccination	㉕ BCG	㉖ Measles	㉗ Infantile paralysis	㉗ D.P.T.	
1								
2								
3								
4								
5								
6								
7								

III. Record of Health Worker's Follow-up

㉙ Date of Visit	㉚ Name of Visitor	㉛ Reason of not practicing FP	㉜ Content of Guidance	㉝ Date of visit	㉞ Name of visitor	㉟ Reason of not practicing FP	㊱ Content of guidance
19 ...							
19 ...							
19 ...							
19 ...							
19 ...							

Reasons of not practicing FP

1. Wants son
2. Wants daughter
3. Wants more children
4. Parent or husband opposed
5. No money for contraceptives
6. Fear of side effects
7. Ashamed to get cont.
8. Don't know where to get cont.
9. Don't know which method is good
10. Sterile
11. Others

Ref. No. :
To :
Reference :
Subject :

FAMILY PLANNING PROGRAM STATUS REPORT(PROVINCE)

Date of Issue 19 . . .
From

Report Period				
Process	Reporter	Varification	Comparison	Statistician

(Side 1)

Name of Office	I. Personnel								II.Registration			III. IUD,					IV. Vasectomy			V. Female sterilization								
	Total		Si,Do		Si,Gun Ku		Eup, Myun		⑨	⑩	⑪	⑫	⑬ Current month			⑭	⑮	⑯	⑰	⑱	⑲ Current month				⑳ Annual cumm. total			
	① AP	② CE	③ AP	④ CE	⑤ AP	⑥ CE	⑦ AP	⑧ CE	New	Drop-out	Current total	Annual target	Total	In-sertion	Rein-sertion	Annual cumm. total	Annual target	Current month	Annual cumm. Total	Annual target	Total	Lapa-ras-cope	Mini-lap	Other	Total	Lapa-ras-cope	Mini-lap	Other
Total																												

* AP = Authorized Positions.

CE = Current Employees.

(Side 2)

Name of office	VI. M.R.			VII. Condom										VIII. Oral pill										IX. Loop inventory			
	㉑ Annual target	㉒ Current month	㉓ Annual cumm. Total	㉖ Monthly average target	㉕ Beginning inventory	㉘ Received	㉗ Distributed	Current month		Paid		Free		㉔ Final Inventory	㉟ Monthly average target	㊱ Beginning inventory	㊲ Received	㊳ Distributed	Current month		Paid		Free		㊺ Final inventory	㊻ Total	㊼ № 3 30.0 %	㊽ № 4 27.5 %
								㉙ Pers	㉚ Amount	㉚ Pers	㉛ Amount	㉜ Pers	㉝ Amount						㊴ Pers	㊵ Amount	㊶ Pers	㊷ Amount	㊸ Pers	㊹ Amount				

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Ref.No. :
To :
Reference:
Subject :

Date of Issue 19 . . .
From

FAMILY PLANNING PROGRAM STATUS REPORT (EUP, MYUN, DONG)

Report Period				
Process	Reporter	Verification	Comparison	Statistician

Name of organization:

1. Personnel					2. registration			3. IUD					4. Vasectomy			
Eup, Myun, Dong,	① Authorized positions	② New employees	③ Vacancies	④ Current employees	⑤ New	⑥ Drop-out	⑦ Cumm. total	⑧ Annual target	⑨ Current month			⑩ Annual cumm. total	⑪ Annual target	⑫ Current month	⑬ Annual cumm. total	⑭ Annual target
									Total	In-sertion	Rein-sertion					

5. Tubal ligation								6. M.R. Kit			7. Condom				
⑮ Current month				⑯ Annual cumm. total				⑰ Annual target	⑱ Current month	⑲ Annual cumm. total	⑳ Average monthly target	㉑ Beginning inventory (end of last month)	㉒ Additional supplies received	Current month	
Total	Lapa-rascope	Mini-lap	Others	Total	Lapa-rascope	Mini-lap	Others							㉓ Number of pers	㉔ Amount

8. Oral pill												9. Loop
Paid		Free		㉘ Final inventory	㉙ Average monthly target	㉚ Beginning inventory (end of last month)	㉛ Additional supplies received	Current month		Paid		Free		㉜ Final inventory	㊵ Total
㉕ Number of pers	㉖ Amount	㉗ Number of pers	㉙ Amount					㉝ Number of pers	㉞ Amount	㉟ Number of pers	㊱ Amount	㊲ Number of pers	㊳ Amount		

inventory		10. Condom fee		11. Oral pill fee	
㊶ No. 3	㊷ No. 4	㊸ Current month	㊹ Cumm. total	㊺ Current month	㊻ Cumm. total

SUMMARY SHEET OF VILLAGE FAMILY PLANNING PROGRAM STATUS

Date of Visit	Name of Worker	No. of Eligible Women	No. of Cont. Users / No. of New Acceptors *							Non Users **				No. of Births and Parity					IE&C Activities		
																			Meetings		No.of Readers of "Happy Home"
			Total	V	T	L	P	C	O	Total	P	S	O	Total	1st	2nd	3rd	4th or more	Meetings	Attending	
19 ...																					
19 ...																					
19 ...																					
19 ...																					
Total																					
19 ...																					
19 ...																					
19 ...																					
19 ...																					
Total																					

* V - Vasectomy T - Tubal ligation L - Loop P - Oral pill C - Condom O - Others
** P - Pregnancy S - Sterilization O - Others

APPENDIX 3

JOB DESCRIPTIONS

1. Provincial family planning sub-section chief

Responsibility	Activity	Information used	Forms and record used
1. Program Planning	1.1 Divides provincial target received from MOHSA among health center	Target	
	1.2 Allocates health center budgets		
	1.3 Reviews provincial supervising nurses activity plans		
2. Management of FP personnel	2.1 Decides appointments of designated doctors		
3. Management of mobile vans (mobile van team leader)	3.1 Plans van itinerary and assigns attendents		
	3.2 Purchases van supplies		
4. Supervision	4.1 Supervises health center family planning sub-section chief activities		
	4.2 Monitors designated hospitals and/or doctors to discover cases of serious contraceptive side effects and determine responsibility		
	4.3 Monitors family planning program progress especially budgets and equipment		
	4.4 Supervises PPFK branch 1. Budget 2. Activities 3. Management		

Responsibility	Activity	Information used	Forms and record used
5. Contraceptive supplies and equipment	5.1 Sets standards for hospitals receiving sterilization equipment		
6. Reporting	6.1 Checks reports and attests their accuracy		

2. Provincial family planning supervising nurse

Responsibility		Activity	Information used	Forms and record used
1. Program planning	1.1	Target allocation to health center	1. Eligible couples 2. Previous yrs. achievement	1. Monthly report
	1.2	Target re-allocation	1. Cumulative achievement 2. Area characteristics	1. Monthly report
	1.3	Target achievement monitoring	1. Target achievement	1. Monthly report
	1.4	Recruitment of family planning workers for training program	1. Personnel reports	1. Central registra-
2. Management of FP personnel	2.1	Review qualifications of designated doctors		
	2.2	Recruit paraprofessionals to insert IUD		Central registration file
	2.3	Review qualifications of FP workers		
	2.4	Detects unqualified FP workers		
	2.5	Recruits family planning workers	1. Vacancies	Monthly report
	2.6	Supervision of family planning field workers activities		Monthly report Central registration file

Responsibility	Activity	Information used	Forms and records used
3. Mobile team management	3.1 Mobile team support activities 1. Disinfect van 2. Distribute FP information from van 3. Fill in for regular mobile team nurse		
4. Supervision	4.1 Supervise health center senior workers (and family planning center workers in urban areas)		Duty diary
	4.2 Supervise designated hospitals 1. Medical record keeping 2. Patient satisfaction 3. Check on who is actually providing service 4. Check sterile technique		
	4.3 Overall program supervision 1. Follow up service 2. Inventory 3. Fees collection 4. Travel vouchers 5. Mothers club activities 6. Family health record keeping 7. Referral of serious side effects for treatment 8. Form and record keeping		Medical records Supply records and receipts Duty diary

Responsibility	Activity	Information used	Forms and records used
5. Contraceptives supplies and equipment	5.1 Distribute supplies received from MOHSA		
	5.2 Provincial warehouse management		
	5.3 Check health center sture rooms		
	5.4 Decide which hospitals should receive sterilization equipment 1. Assist in preparation of forms needed to procure equipment		
6. Reporting	6.1 Keep records and file reports 1. No. of designated hospitals and changes in number 2. Travel reports 3. Health center activity check-list 4. Monthly report 5. Health center evaluation check-list 6. Side effects report 7. Operation fees payment report 8. Pill and condom supply record 9. Receipts 10. Miscellaneous reports 11. Tabulation of slum area achievement reports (urban areas only) 12. Mothers club activities records 13. Overall province achievement analysis report (methods by acceptor characteristics) coupon analysis		

Responsibility	Activity	Information used	Forms and records used
7. Others	7.1 Coordination with other programs and with civil officials		

3. Health center family planning sub-section chief

Responsibility		Activity	Information used	Forms and records used
1. Program Planning	1.1	Divide health center target among fieldworkers (yearly)	Previous years achievement	Monthly report
	1.2	Divide monthly health center target among areas	Previous month's achievement	Monthly report
	1.3	Plan local IE&C activity program	Past achievement of IE&C activities (No. of group meetings, etc.)	
2. Personnel Management	2.1	Appoint fieldworkers		
	2.2	Recommend designated doctors for appointment		
	2.3	Approves/disapproves locational assignments of fieldworkers		
3. Supervision	3.1	Reviews daily activity reports of fieldworkers		Daily log
	3.2	Attests accuracy of monthly achievement reports after checking coupons		Coupon
	3.3	Program evaluation (examines daily log and achievement log)		Daily log achievement log
	3.4	Detection and referral of serious side effects	Complaints	
	3.5	Identify local program problems	Target to achievement	Monthly report

Responsibility		Activity	Information used	Forms and record used
4. Contraceptive supplies and equipment	4.1	Check inventories		
5. Reporting	5.1	Check contents of reports and records completed by others		

4. Health center family planning senior worker

Responsibility		Activity	Information used	Forms and records used
1. Program planning	1.1	Divide health center target among fieldworkers	Previous years achievement	Monthly report
	1.2	Divide monthly targets among areas	Previous month's achievement	Monthly report
	1.3	Plan local IE&C activity program		
2. Personnel management	2.1	Assign fieldworkers to areas	Area achievement & characteristics fieldworkers past achievement and characteristics	
	2.2	Be aquainted with number, location and status of designated hospitals, clinics and physicians		Report of authorized physicians
	2.3	Assist with paperwork necessary to become a designated Dr. or facility		
	2.4	Monitor qualifications and movement of local FP_workers		
3. Supervision	3.1	Make family planning fieldworker's visiting assignments	Area achievement	
	3.2	Help plan street campaigns, visit street stalls, instruct in street campaign techniques		
	3.3	Review visit reports confirm that visits actually carriedout		Travel (visit) record

Responsibility	Activity	Information used	Forms and record used
	3.4 Supervision of designated hospitals 1. Medical record keeping 2. Patient satisfaction 3. Check on who actually provides service 4. Check sterile technique and general sanitary conditions 5. IUD inventory check	Target achievement	
	3.5 Identify local program problems		
	3.6 Make supervisory visits to health sub-centers 1. Check follow-up activities 2. Check coupon issue 3. Check record keeping 4. Check inventory 5. Identify local problems (resolve if possible)		Monthly report
4. Direct service activities	4.1 Distribute supplies to acceptors during street campaigns		
	4.2 Speak at group meetings 1. Ban meetings, mothers club meetings, etc.		
5. Contraceptive supplies and equipment	5.1 Inventory and storage		
	5.2 Check fees collected against supplies distributed		Pill and condom supply list

Responsibility	Activity	Information used	Forms and records used
6. Reporting	6.1 Prepare health center monthly report		
	6.2 Update fieldworkers central registration file		
	6.3 Coupon check		
	6.4 Fill out fieldworker performance evaluation record		
	6.5 Files official documents		
	6.6 Others		

5. PPFK IE&C officer

Responsibility	Activity	Information used	Forms and records used
	1. Advise mothers clubs		
	2. IE&C activity 2.1 Broadcast FP spots over village loudspeaker systems 2.2 Audio visual education (slide and film showings) 2.3 Address group meetings 2.4 Insert family planning information in local administrative bulletins		
	3. Collect PPFK membership fees		
	4. Make Happy Home bundle deliveries to mothers clubs, etc.		
	5. Make quarterly tabulations of family health record items		
	6. Complete monthly progress reports 6.1 Work plan for coming month 6.2 Contacts with mothers clubs 6.3 Report IE&C activities conducted 6.4 Number of PPFK members 6.5 Budget expenditures		
	7. Record keeping 7.1 Duty diary 7.2 Trip reports 7.3 Motorbike trip and mileage record 7.4 Inventory of IE&C materials		

6. Health sub-center family planning worker (fieldworker)

Responsibility		Activity	Information used	Forms and records used
1. Contraceptive	1.1	Visits eligible couples (door knocking)		
	1.2	Delivers pills and condoms to acceptors during visits		
	1.3	Family planning consultations		
	1.4	Referral for clinical methods		
	1.5	Distribute family planning information during other MCH activities such as innoculation campaigns		
	1.6	Distribute contraceptives to FP auxilliaries (mothers club leaders, etc.)		
2. Follow-up service	2.1	Give side effects consultations		
	2.2	Refer and report serious side effects		
3. Others	3.1	Decide areas to be canvassed		
	3.2	Evaluate own progress		
	3.3	Assist and guide mothers club leaders		
	3.4	Assist mothers club leader in keeping family health record		

Responsibility	Activity	Information used	Forms and records used
	3.5 Record keeping and reporting 1. Coupon 2. FP registration list 3. Acceptor lists 4. Pill and condom supply record 5. FP registration record 6. Duty diary 8. Spot report 9. Others		

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