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韓國保健開發研究院

Report of Workshop on Evaluation of New Health Workers in Primary Health Care

August 29-September 1, 1979

FOREWORD

The importance of primary health care was reaffirmed at the Regional Conference of WHO held in Manila in 1977, and at the international Conference on Primary Health Care which convened at Alma Ata, Russia in 1978. Presently, many nations, advanced and developing alike, are showing an increasing interest in the area of primary health care for the improvement of national health.

The Korea Health Development Institute, (KHDI) is currently implementing a primary health care project, "Community Health Project", at the three demonstration sites; namely, Hongchun Gun, Gangwon Province; Okgu Gun, Julla North Province; and Gunee Gun, Gyeongsang North Province. Needless to say, foreign and Korean health and medical disciplines have indicated their deep interest in the demonstration project.

At this stage of project implementation, it is desirable and critical to have an interim evaluation of the new health workers developed under this Project. These health workers, newly developed and utilized by KHDI in the projects, presented their cases and field experience; the training of field health workers and their performance are assessed; solutions to the problems are identified, and finally, the most optimum approach is induced to enable us to formulate national health policies for improved and effective primary health care services.

The workshop on "Evaluation of New Health Workers Training Program and their Field Performance" was held at the KAL Hotel, Cheju City, Cheju Island, under the joint auspices of the USAID Mission in Korea and KHDI, during the period of August 29, 1979 to September 1, 1979. This report summarizes the results of the workshop. Contained in the report are keynote speeches, paper presentations, case presentations, panel and group discussions.

I would like to take this opportunity to express my deep gratitude to distinguished speakers, debators, all the participants, Mr. William E. Paupe, AID Representative in Korea, the Representatives of WHO and UNICEF, without whose support this workshop could not proceed with success. Also, I would like to thank the members of the Steering Committee who made such excellent arrangements for this workshop.

Younghat Ryu, M.D.
President
Korea Health Development Inst.

Report of Workshop on Evaluation of New Health Workers in Primary Health Care

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I. Introduction

Ever-growing interest in primary health care throughout the world is a clear indication that the importance of this care is gradually being recognized by the public. The World Health Organization (WHO) defines the primary health care as, "an integrated approach of versatile measures to improve the national health at community level". As labeled by WHO, primary health care is not only concerned with health care delivery in a narrow sense, but it is also related to community development in a broader sense. It is therefore desirable that health workers be trained and utilized so as to actively take part not only in improving residents' health, but also in developing the community in close collaboration with the inhabitants, and that the health care administration system be improved to support their activities.

"Alternative Approach to Meeting Basic Health Needs in the Developing Countries" was the recommendation of the WHO and UNICEF joint study. This was presented to, and approved at, the Twenty-eighth World Health General Convention. The Alternative Approach stated that the primary health care workers are the persons who engage in disease prevention and curative activities, and also health promotion within the overall health care networks, thus implying the possibility of having trained non-professional health workers to render medical care services. In fact, many countries, advanced as well as developing, have trained and utilized the primary health care workers under the names of Medex, Family Nurse Practitioner, Physician Assistant, Medical Assistant, Community Health Workers, etc.

Truly, primary health care is the first contact of the national and public health care facilities at all levels which offers medical-health care benefits to an individual, his family and community. It is a basic medical service with easy accessibility available at the closest locations.

Delivery of primary health care is achieved through health personnel, including physicians and non-physicians. It is therefore no exaggeration to say that its success depends on adequate training and effective utilization of health personnel who possess the capabilities and a sense of duty. Likewise, the success or failure of the primary health care demonstration project (Community Health Project) which is being carried out by KHDI at three guns will be determined by the quality and quantity of the activities of new primary health care workers, such as community health practitioners, community health aides, and village health agents, the level of coordination and support of the administrative authorities, and the degree of involvement of the community residents.

In summary, through this workshop, the problems and issues associated with the daily activities of health workers will be revealed and identified, and at the same time, strategies and recommendations for the expanded use of such primary health care system will be presented and discussed.

II. OBJECTIVES

1. To analyze and evaluate training regarding selection, processes, material and activities of the health workers, newly developed CHP's, CHA's and VHA's, employed at the community health project (primary health care) areas in conjunction with the effects of the project. Also to identify problem areas of the program and to work out a way of resolving them.

2. To assess new health workers' functions, roles and performance in terms of consumer accessibility, coverage, impact on target population.

3. To promote the understanding of related medical institutions and specialists by comparing their regional features of demonstration sites. To lay out schemes for effective trainings and activities to be conducted and performed in the future.

4. To map out strategy in relation to expanding the implementation of the new type of health workers system.

III. WORKSHOP PROCEDURES AND ORGANIZATION

The workshop was held at the KAL Hotel in Cheju City from August 29-September 1, 1979. It was attended by 55 representatives from the authorities concerned, universities, relevant research institutions, Gun communities, and health demonstration project sites. The participants were largely divided into the plenary sessions and group discussions.

Themes and case presentations of the health demonstration projects were reported at the plenary sessions, and submitted topics were discussed at the three separate discussion groups.

The conclusions and pertinent recommendations were proposed by an ad-hoc sub-committee to the government and related institutes.

Discussions and questions raised at the plenary sessions and group discussions were as follows;

A. Themes

1) Keynote speech: Role of new health workers in the primary health care

2) Selection and training of health workers (CHP, CHA & VHA) in the community health project

3) Function and role of health workers in the community health project

4) Expectations from the activities of new health workers

5) Existing health program and community health projects

6) Evaluation of primary health care workers, observed from the standpoint of the community residents

7) Evaluation strategy and method of approach to the work performance of the community health workers

8) Evaluation method of the project implementation of health workers

B. Discussion Group

First Group Discussion	:	CHP's role and function, training, problems and constraints, etc.
Second Group Discussion	:	CHA's role and function, training, problems and constraints, etc.
Third Group Discussion	:	VHA's role and function, training, problems and constraints, etc.

The preparations were made by the joint efforts of the KHDI staff members and the AID Representative, as listed below on page 270.

C. Organizational Committee

In order to efficiently conduct the workshop, the preparatory committee was organized, composed of eight KHDI staff members as listed below. Major items on the agenda were discussed and agreed upon with Mr. Paupe, AID Representative.

Case presentations related to the project activities implemented by the new health workers (CHP, CHA & VHA) employed at the demonstration areas were collected in collaboration of relevant Gun health centers, and were presented to the workshop by nine selected reporters- one CHP, CHA and VHA from each individual Gun area.

The committee members were:

Secretary General	:	Chung, Chong-Myon
Chief, Health Project Div.,	:	Lee, Sung-Woo
Chief, Manpower Development Div.,	:	Yoone, Kil-Byoung
Chief, Planning & Research Div.,	:	Kim, Chu-Hwan

Chief, General Affairs Div.,	:	Chung Woo-Taek
Senior Researcher	:	Joo, Shyn-Il
Senior Researcher	:	Nam, Chul-Hyun
Senior Researcher	:	Kim, Jin-Soon

IV. SUMMARY ON THE PROCEEDINGS AND DISCUSSIONS AT THE PLENARY SESSION

Plenary Session I (August 29)

An opening speech was delivered by the President of KHDI, Dr. Younghat Ryu, and congratulatory speech was delivered by the Vice Minister of Health & Social Affairs, Mr. Park Sung Ham, and also by Mr. William E. Paupe, USAID Representative. The Governor of Cheju Province then extended his welcome to the participants at the opening ceremony.

Beginning at three o'clock, under the chairmanship of Dr. Younghat Ryu, President of KHDI, the first plenary session took place, and the chairman introduced the key note speaker, Dr. E-Hyock Kwon, Chairman of the Board of Directors of KHDI to the audience, Dr. Kwon delivered a key-note speech entitled, "The Role of New Health Workers in Primary Health Care Service Today".

Outline of the key-note speech

A paper on the "Selection and Training of New Health Workers in Primary Health Care" was presented by Mr. K.B. Yoone, Chief of Manpower Development Division, KHDI. His paper covered the following aspects and factors in detail;

- need of health workers in Korea
- roles and functions of health workers
- selection and criteria of health workers' recruitment
- management of the health workers training program
- development of curriculum content and training material
- detailed scope of health worker's activities and services
- evaluation of health workers training
- training of Community Health Aides
- Training of Village Health Agents

Another paper on the "Functions and Roles of Health Workers in Primary Health Care" was introduced by Dr. Sung Woo Lee, Chief of Health Project Division, KHDI and his paper briefly covered the following aspects:

- role and function of the Community Health Practitioner: curative aspects, patients referral, MCH, family planning, TB patient control, preventive measures and administrative aspects of PHU.

- role and function of Community Health Aides: program planning aspects, assessment of community health needs, MCH, family planning, TB patient control, preventive measures, and record keeping & reporting.

- role and function of the Village Health Agent: help villagers with the problems of family planning, MCH, and TB

- collection and keeping various health data and information

- handling and issuing of simple drugs (five items)

Following the above mentioned papers, the floor of the plenary session was opened for discussions, questions, and answers regarding the topics covered by the two speakers. the hightlights of the questions and discussions at this plenary session can be summarized as follows:

- Is there any consideration or plan to implement a primary health care service program in urban areas?

- May we know the reasons why licensed registered nurses have been given priority preference in selection of Community Health Practitioner?

- What is the reason why male health workers were not recruited as they were in some other countries in Asia?

- What is the proportionate number of male Village Health Agents in your demonstration program?

- from what has been reported by the speaker's on the role of multiple health workers rather than single purpose workers, have any limitations or difficulties been encountered in the course of discharging field service activities?

- regarding have the referral cases sent by the Community Health Practitioner, how far have follow-up assessment approaches been done for those referral cases?

Plenary Session II (August 30th)

The second plenary session proceeded with the Chairmanship of Professor Sung Kwan Lee, College of Medicine, Kyongbuk University. Three CHP speakers Miss Mansoo Woo, Hongchon; Miss Kyongai Kim, Okgu; and Mrs. Kyongnam Kang, Gunee. They delivered a case report on their actual activities and achievements which they carried out at their primary health unit, including some of the problems and difficulties encountered since their deployment.

Following the case presentation by the three Community Health Practitioners, discussion and questions were raised from the floor, and are summarized as follows:

- workload of CHA's including much record keeping appears to be quite heavy and the means of transportation for emergency cases are not easily accessible. What measures would be recommended to solve these difficulties for the CHP's?

- what are the problems encountered in helping medicade relief patients and in enlisting the cooperation of those doctors with limited-scope licenses

- legal provision to ensure the status of Community Health Practitioner may be urgently needed to safeguard future services of CHP health workers. It may also be advisable to find male health workers (CHA) to dispatch to off-shore islands

- it may be essential to start educating lactating mothers with baby-feeding and weaning methods

- what are adequate ways of health care services in the Primary Health Care unit during the weekend and holiday seasons?

- what are the actual contributions if any, by private medical practitioners for Primary Health Care Services in demonstration areas so far?

Proceedings of the Third Plenary Session (August 30th)

The third plenary session proceeded with the chairmanship of Professor Il-Soon Kim, Yonsei University. The Chairman introduced the first speaker, Mr. Jae-Hyun Cho, Chief of Public Health Section, Kyoungsang Buk Do Province, who delivered a paper with the subject, "Expectations of Health Services rendered by New Health Workers from the Consumers' Point of View."

The highlights of Mr. Cho's speech can be summarized as follows:

- out of 247 doctors deployed in Kyoungsang Buk Do Province, too many are working in urban cities, or Eup areas; thus the remaining 67% of the Myon areas are without the availability of medical services at present.

- under these circumstances the provision of medical services for rural Myons is an imposing problem. Thus, some solutions such as KHDI's CHP in PHC Services approach may be quite an appropriate venture for the rural people in remote villages and Myons

- furthermore, comprehensive Primary Health Care Services, with preventive measures, as well as curative measures, are a very significant and important policy solution suitable for the province

- in the case of the Gunee Gun Health Demonstration Project, it is understood that rural people are quite happy to have easy access to Primary health Care Services all the time since the inception of the KHDI project

- it is also understood that the newly deployed health workers are playing a very important role, not only as curative and preventive service health workers, but also at times as rural community leaders in helping educate the people in health and sanitary matters, as well as other community development activities

- it can therefore be concluded, as far as the speakers have observed, that the development and implementation of a Primary Health Care System with new health workers is a very desirable and indispensable program for the ultimate solution of the rural people's health problems

The second speaker at this plenary session was Dr. Koo-Woong Han, Director of the Gunee Health Center. He delivered a paper with the title of, "Comparative Observation of Existing Public Health Service and the Maul-Geon-Gang-Saup".

Hightlights of his can be summarized as follows:

- Dr. Han has pointed out that unlike previous public health services, the new Maul-Geon-Gang-Saup has extended the scope of services to the village level through the establishment of Primary Health Units and Myon-levll primary health Sub-posts.

- The speaker also pointed out that five CHP's in Gunee Gun served more than 4,300 persons during the period from July, 1978- to June, 1979. Thus, the monthly average number of persons receiving curative services amounted to 360. He also pointed out that services of pre-natal and delivery cases, as well as the registration and inoculation of babies, has thus been greatly improved

- the speaker also noted that there are a number of problems and difficulties being faced in carrying out the primary health care service system. They are indicated below:
a. Lack of service facilities and equipment.
b. Lack of a sound referral system between the primary and secondary service
c. Need to improve patient examination skills by CHPs.

- regarding family planning services, the speaker pointed out that about seventy percent of the services increased during 1979, although there are a number of problems such as the persistence of a boy-preference attitude, lack of family planning motivation and lack of education of mothers regarding family planning

- he made the following recommendations for the improvement of the primary health care system in the demonstration area;

a. The primary health care system should be expanded to a larger scope, including health and sanitary education. Community participation should be strengthened with the better use of new health workers, such as the CHP, CHA and VHA
b. In order to improve health workers' skill, in-service training should be given more often to the workers
c. A stronger referral system should be established between the Primary Health Unit (PHU) level and the Upper level
d. The future out-look of Community Health Service, or PHC, will be brighter if service quality can be improved and education of the people can also be improved

Following the delivery of a talk on "The Comparative Observation Between Existing Health Services and Maul-Geon-Gang-Saup", by Dr. K.W. Han, the floor was opened to discussion, and a question and answer session. The highlights of the questions raised are summarized as follows:

- what plans or provisions can be envisaged with regard to the solution of current salary differences between existing Health Center workers, such as public health nurses or aides and those Health Workers engaged in the Maul-Geon-Gang-Saup?

- what is the solution to the conspicuous turn-over rate (25% per year) of health workers existing at present?

- there is a need to ensure the employment status of CHP type present health workers from cateogry "eight", temporary appointment status, to a permanent local government employee status, lest they should be dropped from the job in both demonstration area and other Guns

- as for the future prospects and sound development of primary health care services in off-shore islands, some serious measures may be necessary to improve the present worker placement system, (from preferably female workers to male workers)

- for female workers who are of marrying age and deployed in remote areas of service, some compensatory reward and marriage guidance system may be needed to keep their working morale higher

Plenary Session IV (August, 30th)

The fourth plenary session proceeded under the chairmanship of Pro. Yun Chul Koo, College of Medicine, Ewha Women's University.

Three Community Health Aides (CHA) speakers were introduced; Miss Kyongae Lee, Gunee Gun; Miss Kyoung Ja Huh, Hongchon Gun; and Miss Jum Sook Kim, Okgu Gun.

They delivered detailed account of their actual activities and achievements carried out through the case record paper entitled, "Case Presentation of Community Health Aides Field Activities".

Following the deliveries of the three Community Health Aides from different demonstration counties, the floor of the plenary session was opened to discussion, and questions and answers. The highlights of the issues and questions raised are summarized as follows:

- according to the presentation of the report there are many officers leaders of the Village-Level community development-oriented organization. How are those woman leaders located or appointed in such small villages when only 70 or 80 households reside there?

- in an attempt to locate health problems and needs, which of the two following ways has proven to be the most effective approach; problem finding through home-visitation by health workers, and/or through counseling and interviews held at the Primary Health Centers or Primary Health Units?

- in the case of activities of the Village Health Service, Hongchon Gun, utilization of a basic drug-chest was mentioned by the Village Health Agent. The question is, what is the reaction of the local pharmarcist or drug store regarding the system of a medicine chest being distributed to a village

- more information was requested regarding actual operational aspects of Dae-dong Hoe Medical Cooperative in Hongchon Gun.

- the question was asked regarding how actual servicing time can be allocated for home-visiting and community service by CHA's or VHA's, and what are the actual contents of the drug chest kept by them

- the floor wanted to know about the charge for curative services being paid by Dae-dong Hoe members to the Primary Health Unit, and the criteria used for the calculation of the charges for medical care for membership card holders

Following the discussion after the delivery of the talk by Deputy County Chief, Okgu Gun, Mr. Young Kyoo Lee, the Chairman of the Plenary Session, Prof. Yun Chol Koo, Ewha Women's University, introduced three subsequent speakers of Village Health Agents from three demonstration Guns. These three poeple were Mrs. Yoon Ok Kang, Okgu Gun; Mrs. Chongju Kim, Gunee Gun; and Mrs. Boksun Chang, Hongchon Gun.

Although there are slight variations in the order and contents of deliveries by the Village Health Agents, they generally covered their community environment, daily activities, features of their services to the people, some problems they have overcome and their proposals to the authorities concerned to improve their mission in the future.

Actual case records they have written and presented are attached as a separate document in Korean, and English to the Reports of this Seminar.

Following the presentations on activities of the Village Health Workers, the floor was brought open to a question and answer session. The highlights of the issues raised are summarized as follows:

- How the integrated health and sanitary services are carried out at the village level, whereas the Saemaul Women's Association is in charge of conducting services related to sanitation, health and education of women in their communities.

- An opinion was expressed that it is desirable for KHDI to develop a clearer scope of each type of health service worker, including Village Health Workers, based on the Research work of the KHDI demonstration project.

- An opinion was expressed that it is desirable for KHDI to train and develop competent Village Health Workers within the premises of Dae Dong Hoe Medical Cooperative Organization and a supportive network to the Primary Health Unit or Post.

- The question was asked as to how to replace trained Village Health Workers when they resign within a village where trained women leaders are so few.

- A member from the floor wanted to know how many hours the Village Health Worker serves in home-visitation and other related services when she is also heavily involved in home affairs and other roles as a resource leader.

- How is the supply of simple medicines for the drug-chest maintained and funded to insure a steady supply.

- In the case of no available quality health care workers, such as CHP's or CHA's for delivering mothers, how can the village Health Workers manage to extend such need help for such intense emergency situations.

Plenary Session V (August 31st)

The fifth plenary session proceeded under the chairmanship of Prof. Jung Huh, Dean of the School of Public Health, Seoul National University.

The first speaker, Dr. Choo Whan Kim, Chief of Planning and Research Div. KHDI, was introduced. Dr. Kim delivered a talk from a prepared paper entitled, "Approaches to an Evaluation of New Primary Health Care Worker's Activities".

The talk covered the following issues based on the KHDI health care demonstration projects:

- Conceptualization of project-based evaluation

- Determination of factors and items of the evaluation program in primary health care: factors to take into consideration and information needed in determining evaluation items.

- Processes and steps to conduct the evaluation of health worker's activities; Indicators and standards or criteria to adopt.

- Implementing body or organization for evaluation of health workers.

- Results and achievements of health worker's activities which contribute to the evaluation of KHDI health service projects in three demonstration areas.

Following the presentation of the topic by Dr. C.W. Kim, the floor was opened by the Chairman of the session, Prof. Jung Huh, for discussions, questions and answers, and the highlight of the issues raised are summarized as follows:

- It may be a dangerous approach if only numerical aspects of activity results are evaluated without taking into consideration the health system, administrative organizational factors and environmental characters such as population coverage, geographical net work, the type of curative and preventive services rendered by Health Workers and the utilization of results as a means of steady feed-back.

- In an attempt by KHDI to evaluate the achievements and activities of new health workers, one has to consider a number of factors in order to conduct the evaluation, such as:

a) Financial and administrative aspect.
b) Actual operational aspect as a responsible organization in charge of program implementation
c) From an independent outsider's viewpoint in order to avoid possible biases.

- In planning evaluation work, one has to consider the primary health care service in relation to the secondary and tertiary delivery system of the medical care within the concerned area.

Following discussion on the previous topic, Prof. Jung Huh, introduced the second speaker, Prof. Kyung Kyoon Chung.

Prof. K.K. Chung delivered a talk entitled, "Assessment of Health Worker's Activities," The highlights are as follows:

- One has to seriously consider whether or not over one hundred indicators should be prepared of the Health Workers in making evaluation scales, since, as the previous speaker has illustrated, there are more than eighty job-functions of the new Health Workers and Community Health Practitioners.

- One has to take the following external factors into consideration because these outside factors create a great impact in the course of attaining good work-performance from the health workers;

  a) Supervisory function of the health care system from the top to the field

  b) Adequacy of salary remuneration, medical equipment and office supplies.

  c) Timely management, optimum leadership and adequate operational guidance.

  d) The speaker also pointed out that not every case can be identified as a single treatment unit. For example, the length of time taken for a flu patient is three to five minutes, whereas a delivery case may require three to five hours by a CHP.

  e) It may also be advisable to not only conduct an evaluation by the implementing agency, that is KHDI, but also through an outside agency or academic research body like a university institute using the appropriate application of various independent and dependent variables as much as possible.

Following the talk by Prof. K.K. Chung, the entire group divided into three sub-groups to discuss each CHP, CHA and VHA-type worker with respect to the adequacy of training methods, and the contents and results in relation to each of their field activities.

Plenary Session VI (August 31st)

The Sixth Plenary Session proceeded under the Chairmanship of Dr. Chong Kee Park, KDI. As an opening remark, the chairman declared that the task of this particular plenary session is to study the chairman's report of each the three groups to be presented orally to the floor with mimeorgaphed paper to further discuss the issues if any doubts exist or if clarification is required for recommendations to the government.

Major issues, discussions and questions raised following the three chairmen's reports are summarized as follows:

- A distinct need was expressed with regard to providing some remunerative measures for village voluntary health workers as an incentive to maintain their enthusiasm and boost their moral.

- With regard to expansion and future strategy, close coordination between the Saemaul Undong Movement through Saemaul Women's Asso. and the health care services was mentioned.

- It is urgent that we recommend the government to take up, as a policy, the provisions of the Primary Health Care Delivery system in the near future.

- With regard to CHP training and development, qualitative improvement and ample practice with increased competency of skill is indispensable.

- Training of health workers in the future should be closely geared to the rural community situation and the needs of grass-roots people.

- As for the improved use of the training material, more A-V material is planned and a broader scope to include nutrition material, health educational media, preventive aspects, and rural community development plan may be added in the future.

- In conducting follow-up training of New Health Workers, results and findings of on-going evaluations should be kept for future use.

- The Primary Health Service program should be gradually introduced into under-serviced remote areas, such as mountain and island communities and rural townships.

- Field supervision and guidance systems should be advocated into the managerial and operational aspects of the Primary Health Care experimentation project.

Following the chairman's resume on the issues and highlights of problems tackled so far, points of clarification, questions and additional remarks were made and are briefly summarized as follows:

- With regard to the clinical practice of new health workers in training, greater allocation of time may be needed to given them more time for practical experience than what they are currently being given during their pre-service training.

- With regard to CHA's attending to delivery cases, a participant statement discouraging CHA's not to help with the delivery process.

- It was mentioned that there is a distinct necessity to recommend that the government provide health services through middle-level health manpower for rural areas where financial resources and the supply of physicians is currently lacking.

Plenary Session VII (August 31st)

The Seventh Plenary Session proceeded under the chairmanship of Dr. Hyung Jong Park, Ex-president of KHDI. Dr. Park stated that the task of this final session was to review the various reports presented, so far, and the recommendations and relevant issues dealt with in the past three days, and thus enable the secretariat of the workshop to compile a compact and convincing report with recommendations to the government and relevant academic institutes.

Chairman Dr. H.J. Park also briefly summarized some key issues brought about so far at the plenary session as follows;

- In light of the current health care delivery system, the role of local practitioners is very important, and orientation training of these physicians must be strengthened in the future.

- As a group, the floor expressed the opinion to KHDI that they explore the possibility that the government adopt the Primary Health Care system, or Maul-Geongang-Saup, in the 1980's.

- With regard to the improvement of service quality and fulfilment of home-visiting services by CHP's, supervisory doctors or the Director of the County Health Center should actively provide technical guidance in the field or through regular monthly CHP staff conferences.

- It was pointed out that KHDI should strive to prepare a scientific recommendation report to the government to replicate the Primary Health Care service system.

- It was also pointed out that a proposal be requested for resource allocation or budgetary provision and be submitted on a timely basis to E.P.B. by the concerned ministry to back up the proposal raised and adopted by the plenary session in pursuing the adoption of the Primary Health Care system in the fifth five year economic development plan.

- Chairman Dr. H.J. Park suggested that consideration be made to nominate an ad-hoc committee to prepare a formal statement of recommendation to the government to implement a Primary Health Care system after the workshop. The floor unanimously accepted the proposal and requested the chairman to name the said ad-hoc committee and chairman. After a short recess, the following seven members were recommended to the floor, and were accepted with unanimous approval. They are listed as follows:

  Dr. Ku Yeon Chul
  Park Jong Kee
  Yeon Ha Chung
  Kim Il Soon
  Kim Soon Ja
  Two KHDI senior staff members

V. SUMMARY & HIGHLIGHT OF GROUP SESSION

Group 1: Community Health Practitioner's Role and Function, Training, Problems and Constraints, etc.

List of Participants

Dr. Sung Kwan Lee (Chairman)	:	Professor, Department of Preventive Medicine, Gyeongbug University
Dr. Hyung Jong Park	:	Professor, School of Public Health, Seoul National University
Ms. Soon Ja Kim	:	Vice-president, Korean Nurses Association
Mr. Suk Chae Lee	:	Director, Fourth Planning Division, Economic Planning Board
Mr. Hoon Shik Shin	:	Director Third Medical Affairs Division, Ministry of Health & Social Affairs
Dr. Jae Yon Cho	:	Director, Public Health Division, Gyeongbug Province
Dr. Ha Cheong Yeon	:	Senior Researcher, Korea Development Institute
Dr. Sung Woo Lee(Rapporteur)	:	Chief, Health Project Division, Korea Health Development Institute
Dr. Chu Whan Kim	:	Chief, Planning and Research Division, Korea Health Development Institute
Dr. Gwang Jae Lee	:	Director, Okgu Gun Health Center, Okgu Gun, Jeonra Bug Province
Ms. Kyong Ran Kang	:	Community Health Practitioner, Gunee Gun Health Center, Gunee Gun Gyeongsang Bug Province

Ms. Yong Ae Kim	:	Community Health Practitioner, Okgu Gun Health Center, Okgu Gun, Jeonra Bug Province
Ms. Man Soo Woo	:	Community Health Practitioner, Hongchon Gun Health Center, Hongchon Gun, Gangweon Province

The group discussed the subject matter and finalized the following summary and recommendations.

1) Training of Community Health Practitioner

The KHDI's one year training course for community health practitioners, divided into three months' didactic training, three months' hospital clinical practice, and six months' field practice, seems to be adequate. The following points, however, should be considered or included in the future training courses for community health practitioners:

a) During six months field practice, proper preceptors should be selected and assigned to each community health practitioner in training. The trainee can be sent to the existing community health practitioner's post so as to work together with the practitioner for training.

b) A three month hospital clinical training course may be too short, or seasonally inadequate, since community health practitioners under training only have the chance to see the seasonally-limited patients prevalent during that particular season. Therefore, it is necessary to provide supplementary training for one week out of every three months in the hospital in order to broaden their experience in clinical setup.

c) Additional supplementary training is necessary for one week every three months. This training may be substituted with continuous distribution of training materials to the field.

d) The training course should be organized in order to prepare for future training courses for the community health practitioners. In this training course, health center directors, general practitioners in rural areas who have had experience in rural practice, and experienced community health practitioners already working should be included.

e) It is preferable to choose a rural area for the training site of future community health practitioners, instead of big cities such as Seoul, Busan or Daegu.

f) Number of traininees at one time should be no more than twenty.

g) It is necessary to study and revise the previously developed training material of the Korea Health Development Institute in order to meet the needs of the future training courses. In the text of the training material, special local situations, such as health indicators and characteristics of the region should be included.

h) Trainees should be selected from the Gun area where they are going to serve after the training.

2) Function of Community Health Practitioners

The present role and function developed by the Korea Health Development Institute is considered adequate. However, when deciding the scope of role and function, the local health need and demand should be considered and priorities should be established as to which field emphasis should be given. This gap should be filled by those community health practitioners.

At the present time the activities of community health practitioners are oriented to curative services. Though this seems desirous when the present situation is considered, it should be emphasized that in the future, more time should be spent in preventive service activities which are more beneficial than direct curative services.

3) Evaluation of Community Health Practitioners Activities

Evaluation of community health practitioner's activities should be developed for use by direct supervisory staffs in the organization.

4) Strategy for the Replication of Community Health Practitioners

In order to meet the rural health needs and demands, the farmer's capability of paying the health service bills and limited medical manpower resources, the role of public sectors providing medical and health care should be considered.

Under the present rural situation, the Government cannot help but utilize intermediate health manpower such as community health practitioners. When instigating the community health practitioners' activities nationwide, the program must be thoroughly studied to classify the areas of need into several categories in order to identify the most deprived areas.

Though the Ministry of Health & Social Affairs is planning to assign at least one physician to every Myon thoughout the country in the near future, it is still necessary to think of the community

health practitioners planned for these areas.

The community health practitioners may be needed not only in these remote areas, but also in areas where physicians are to help the physicians in routine matters.

In securing the manpower and facilities for future community health practitioners, the following points should be thought of:

a. A rotation system for workers in remote areas.
b. Special rules and regulations to provide better results.
c. Provisions for promotional opportunities for community health practitioners.
d. Special allowances for those serving in remote areas.
e. Reasonable reallocation of the national health budget, such as cutting down the hospital building budget, and better utilization of the existing budget for Myon physicians for community health practitioners.
f. Community role in paying part of the expenses of the community health practitioner's post.

Group 2: Evaluation of CHAs in the current KHDI Primary Health Care Demonstration Projects

List of Participants

Dr. Yun-Chul Koo (Chairman)	:	Professor, College of Medicine, Ewha Women's University
Dr. Younghat Ryu	:	President, Korea Health Development Institute
Dr. Taek-Il Kim	:	Director, Korea Institute for Family Planning
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Mr. Yong-Gyu Lee	:	Deputy County Chief, Gunee County, Gyeongbuk Province
Mr. Michael Park	:	Program Officer UNICEF/Korea
Dr. Young-Joon Ryu	:	Division-Director, Public Health Division, Jeonbuk Province Administration

Mr. Woo-Taek Chung	:	Chief, General Affairs Division, Korea Health Development Institute
Dr. Jung-Ok Park	:	Chief, Community Health Center, Hongchon Eup, Hongchon County, Gangweon Province
Ms. Jin-Soon Kim	:	Senior Researcher, Manpower Development Division, Korea Health Development Institute
Miss Gyeong-Ai Lee	:	Community Health Aid, Gunee Demonstration
Miss Gyeong-Ja Huh	:	Community Health Aid, Hongchon Demonstration
Miss Jum-Sook Kim	:	Community Health Aid, Okgu Demonstration
Dr. Shyn-Il Joo (Rapporteur)	:	Invited Senior Researcher, Health Project Division Korea Health Development Institute

Summary of the Group Discussion

It was the general consensus of the CHA's in the group that the overall CHA training provided by KHDI was adequate in terms of time and contents; furthermore, it substantially complimented the clinical part of the CHA's function as required in the performance of multi-purpose activities relating to family planning, maternal and child health and tuberculosis control.

The next discussion was centered on the problems and issues experienced by CHA's by their post-training activities in the field.

The problems and issues identified by the group were primarily related to the optimum mix of didactic versus practice sessions in the KHDI training component; legal and operational constraints: effective utilization of categorical training aids; and the problem of a paperwork overload.

Various alternatives were discussed in depth in an attempt to reduce the magnitude of the problems and issues in question, thereby finalizing eight items for recommendation.

These recommendations are summarized as follows:

1) Problems and Issues

a. Inadequate time allocation for practice sessions in the training of CHA's, compared to the didactic component of the training.

In particular, additional time allocation for the practice sessions on delivery assistance was stressed. Practice sessions on the preparation of weaning diets, utilizing locally available foodstuffs were also suggested.

b. Insufficient utilization of agencies and audio-visual aids relating to the activities of family planning, tuberculosis control and maternal and child health.

c. Legal constraint, coupled with a limited professional capacity, to attend to emergency cases, such as birth delivery.

d. Difficulty in accomplishing individually assigned monthly targets on the part of CHA's, due to their expanded role and function involved in primary health care activities, ie., health education and environmental sanitation.

e. Too many monthly and daily report forms,(national, local and KHDI, to be filled in by CHAs', which affects the field activities performed by this category of personnel.

2) Recommendation

a. Optimum proportionate allocation for the future training curriculum for CHA's, concerning didactic and practice sessions, with emphasis on categorical services most in demand in rural areas.

b. Earliest printing by UNICEF of operational nutrition manual.

UNICEF/Korea has been developing an operational nutrition manual, and its pre-test was conducted in the three KHDI demonstration counties last February. Its final edition hopefully will be produced by UNICEF/Korea as soon as possible.

c. Efficient utilization of the Korean Institute for Family planning and Korean National Tuberculosis Association by entrusting these agencies with trainees for the relevant components of training requirements.

d. In principle, CHA's will refer delivery cases to CHP's. However, within the legal context of related laws and regulations, CHA's will be adequately trained to cope with immediate cases of normal delivery at hand.

e. Revise the monthly target system currently in practice so as to reflect the quality of categorical services being provided by CHA's.

f. The role and function of a CHA is part of an integral component of primary health care activities in Korea. Thus, effective Korea. Thus, effective utilization of CHA's is important.

g. The nine-month regular training course for nurse-aids will be closely reviewed and analyzed to permit effective priority for ranking and time allocation of training components for the future endeavors of KHDI.

Group 3: Village Health Agent's Role and Function, Training, Problems and Constraints, etc.

List of Participants

Dr. Il Soon Kim (Chairman)	:	Professor, Department of Preventive Medicine College of Medicine Yonsei University
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Mr. Jae Sung Min	:	Chief, Division of Research and Administrative Coordination, NHS Korea Development Institute
Mr. Sang Jin Lee	:	Vice Chief, Gunee Gun, Gyeongsang Buk Province
Mr. Jae Hyun Chang	:	Vice Chief, Hongchon Gun, Gangweon Province

Mr. Dong Bin Jeon	:	Director, Public Health Division Gangweon Province
Mr. Kil Byoung Yoone	:	Chief, Manpower Development Division Korea Health Development Institute
Mr. Chul Hyun Nam (Rapporteur)	:	Senior Researcher Korea Health Development Institute
Dr. Gu Wung Han	:	Director, Gunee Gun Health Center Gunee Gun, Gyoungsang Buk Province
Ms. Yoone Soon Kang	:	Village Health Agent Hongchon Gun, Gangweon Province
Ms. Jeong Ja Kim	:	Village Health Agent Gunee Gun, Gyeongsang Buk Province
Ms. Bok Soon Chang	:	Village Health Agent Hongchon Gun, Gangweon Province

The results of the group discussion are summarized as follows:

1) Training of Village Health Agents

   a. A total of two weeks training should be given to the VHA's per year, with a three day intensive classroom orientation conducted two to three times per year.

   b. In-service supplementary training for VHA's should be conducted at the Gun Health Center or Myon office for one day whenever it is necessary.

   c. Modular text materials for self-study purposes should be developed, with an emphasis on competent skill aspects of the training.

   d. Training methods should be improved to more effectively facilitate the training of VHA's in basic health procedures for their future performance.

   The following should be considered for improving training methods:

   a) Utilization of audio-visual materials, including slides, flow charts and models.
   b) Utilization of CHP's and CHA's in training VHA's at Community Health Centers in such basic care areas as first aid.

e. Community health practitioners, community health aides and staffs of the health centers should be available for the training and instruction of VHA's.

2) Regarding the Selection

Upon the recommendation of the village council meeting, an official nomination or commission by the Gun chief should be given to the Village Health Agent. Because voluntary community participation is in its infantile stage, various activities of VHA's should be based on administrative guidance rather than administrative instruction.

3) Function and Roles of VHA

a. In order to improve community health as a whole, the Village Health Agent should be not only a leader of villagers, but also a volunteer mother of the villager who can interact as a bridge between villagers and the health care delivery system.

b. Comprehensive health education regarding environmental sanitation, MCH services, etc., should be strongly emphasized in the future activities of the village health agent.

c. It is necessary for KHDI to assess the VHA's roles in Hongchon and the other demonstration Guns before recommending future replication.

4) Incentive to VHA

To insure that VHA's perform most effectively, incentive boosters should be incorporated in the programs. It is not recommended that these be in the form of cash (except for travel expenses) but the following are considerations:

a. Official recognition or commission by the Gun Chief

b. Issuing of uniforms

c. Handling basic drugs supply

d. Giving an award or citation to outstanding VHA's

e. Group observation tour of an advanced pilot area.

5) Strategy and expansion of the VHA program

a. It is unanimously recognized that the replication of the village health agent system for the nation-wide health program is necessary. Furthermore, it is considered that the pertinent role and function of village health agents should be drawn up after considering the relative merits of Hongchon Gun-type VHA, and those of VHA's in other Guns in the future.

b. It is agreed that the activities of the village health agent should be developed as one of the functions which boldly stand out in the organization of the Saemaul Women's Club.

VI. SUMMARY AND RECOMMENDATIONS

Summarized below are the conclusions of three group discussions and a set of recommendations proposed by an ad-hoc sub-committee.

1. Conclusions

1) The training duration of the primary health care workers (Community Health Practitioners, Community Health Aides and Village Health Agents) conducted by KHDI is adequate; supplemental training after the normal training is absolutely necessary; and the outcome of evaluations should be fully utilized.

2) It is highly desirable that the trainee is selected from among the natives of the Province (Gun) concerned.

3) The rural area is an appropriate site for conducting the training of health workers: The practical training including clinical or field work, should be given more emphasis.

4) Audio-visual aids, as well as the nutritional guidance textbook developed by UNICEF, should be employed as teaching aids. Their contents must be continuously improved and supplemented for wider distribution and greater use. Self-study manuals of module type, stressing practical use, should be developed to facilitate the activities of Village Health Agents.

5) Directors of community health centers and medical practitioners in rural areas should be employed as instructors; it is highly preferable that such agencies and organizations associated with family planning, tuberculosis control and maternal and child health, etc., be solicited to take an active part in the training of the community health aides: The staff of community health center, the community health practitioners and community health aides should be utilized to the maximum possible degree in training the Village Health Agents.

6) The role and function of the primary health care workers, as defined by KHDI, are considered appropriate. A way should be explored to induce more involvement of health workers in public health education and community development, as well as having the community residents in the health care program actively participating in it.

7) It was observed that the community health practitioner tends to concentrate only on the curative aspect of health services. It is desirable that they should allocate more time and efforts on the preventive aspect, assigning such duties as first aid treatment and attending to normal deliveries to the community health aides (multi-purpose health worker). There is a need to intensify the training of community health aides in these areas with administrative support for them.

8) Excessive reporting requirements for the worker's various formats hinder the smooth and effective implementation of the project and it is felt that these reports should be simplified and consolidated.

9) The evaluation of the performance of the community health practitioner should be continuously conducted during the entire process of institutionalizing the system, together with an effort to develop evaluation methodology. The evaluation criteria for activities of community health aides should be readjusted from the quantitative aspects for achievement of a monthly target, to the qualitative aspects of various services rendered.

10) The expanded use of Village Health Agents on a nationwide basis is necessary. Their role and function should be clearly defined by analyzing the experience gained from the Gunee, Okgu and Hongchun demonstration project.

11) Village Health Agents should be appointed by the recommendation of the community. In this case, however, the government-induced approach. It is recommended that a volunteer mother, as a representative of the community, should be able to play the role of bringing together the residents and the public health care agencies.

12) The Village Health Agent should not be regarded as a new organizational unit leader in competition with the existing Saemaul Mother's Club, Rather, its role should be made an integral part of the activities of the Saemaul Mother's Club within its framework.

13) It is acknowledged that there exists needs to provide incentives of an indirect nature, rather than direct payment of renumeration in cash (excluding the transportation costs), in order to assure that the Village Health Agent performs her role more effectively.

14) It is desirable that in such isolated areas where primary health care services are totally non-existent, the primary health care project should be introduced on step-by-step basis.

2. Recommendations

The purpose of the Workshop is to have an interim evaluation of the activities of new health workers developed and employed in the KHDI demonstration project. In view of its interim nature, it is impossible at this time to produce a set of comprehensive recommendations encompassing all the problems and matters associated with the development of health care workers. What is possible by the evaluators at this time is that the performance of the new health workers so far reviewed is highly successful. It is therefore imperative to see that the KHDI's Primary Health Care Demonstration Project (particularly the health care services delivery system and development of health workers) be brought to a successful end, and that the recommendations that may be derived from the evaluation be appropriately reflected in the government's national health policies.

The recommendations derived so far at this stage are made up of two parts: one addressed to the government and the other to KHDI. A set of recommendation to the government is rather comprehensive in its contents and calls for government action to include the primary health care in the fifth five-Year Economic Development Plan as one of the basic health strategies, and to extend financial supports for its all-out implementation. Recommendations to KHDI include the fact that KHDI should devote its best efforts to the evaluation of the outcome of its demonstration projects so that the lessons and experience can be used in making national health policies. It is decided that specific recommendations will be made separately on the basis of the group discussions and conclusions thereby.

3. Recommendations to Government

A majority of the countries in the world manifest growing interest in the development of a health care delivery system which facilitates the provision of quality health and medical services to the people at reasonable costs. In fact, a great deal of effort has been made by them in exploring a solution to the emerging demand.

As an attempt to seek a solution to this world-wide need, the "International Conference on the Primary Health Care" was held at Alma Ata, Russia, under the joint auspices of WHO and UNICEF during the period of September 6-12, 1978. In addition, the thirty-second World Health General Convention declared an approach to meeting needs of the primary health care as its recommendation to all the nations in the world. Furthermore, the Convention urged that governments and private organizations associated with health, medicine, and community development, and the community itself take immediate initiatives in implementing the primary health care programs for the protection and promotion of the health of the people.

In its pursuit to attain the goal, KHDI is presently implementing the primary health care demonstration project, in which new health workers play a crucial role. An interim evaluation, which was conducted on the village health project (Maul-Geon-Gang-Saup) to measure the performance of new health workers and cost-effectiveness, indicates that the project attained fairly good results

Some of the qualitative and quantitative indications resulting from the evaluation are:

(1) A noted increase in the satisfaction of the inhabitants; (2) rendering of services was timely and appropriate curative and preventive services proved to be adequate; (3) costs were less; and, (4) recipient population sharply increased, and geographically-balanced delivery of services was made possible.

Based on these results, the Workshop proposes the following recommendations to the government:

"It is recommended that the Fifth Five Year Economic Development Plan, which will begin in 1982, adopt the primary health care as an integral part of major health policies and provide all possible supports at the national level"

4. Recommendations to KHDI

It is recommended:

1) that a way to devote its efforts to evaluation of the demonstration project be sought, and that to the most possible extent, Korean professionals and experts in lieu of foreign consultants be utilized in planning, devising, and conducting the evaluation.

2) that an endeavour be made to institutionalize the new primary health care manpower system for wider utilization throughout the country.

3) that KHDI being wholely responsible for the training of health workers, set up a training program in cooperation with other similar training institutions.

4) that the present organization be restructured to maximize the activities of new health workers within the framework of the existing local health administration system.

5) that professional qualification be granted to those who complete the health care worker's regular training course.

6) that administrative supports be extended for CHP's to be able to attend normal deliveries, which is no a part of the activities of health workers.

7) that supplementary training for field health workers be reinforced while they are on the job.

8) that the link with Saemaul Women's Asso. Club be intensified in order to make the activities of village health agents more effective.

9) recommendations presented by each sub-group be later incorporated into this set of recommendations.

I. OPENING CEREMONY

A. Key-note Speech

Role of New Health Workers in Primary Health Care

by Dr. Kwon. E Hyock
Chairman
KHDI Board of Directors

Preface

Korea Health Development Institute was inaugurated in April, 1976, for the purpose of studying realistic and systematic ways of developing a comprehensive national health delivery system and other associated problems in interrelated sectors, thereby contributing to the formulation of the national health plans and policies.

With these objectives, KHDI has been undertaking community health projects at three demonstration sites. The goal of the community health project is to develop an efficient health care delivery system at a low-cost affordable by the residents in remote rural areas, as well as in isolated islands.

It is logical to expect that new health worker programs, such as the "Maul Geon-Gang Village Health Worker's Club", "Community Health Aide", and "Community Health Practitioners" should play a crucial role in carrying out such projects. In fact, the activities performed by the new health workers in the KHDI demonstration project area were remarkable and worthy of high praise. Discussed below are the definitions of the primary health care and the role the new health workers are expected to play.

Primary Health Care and the Alma-Ata Declaration

There are still varying views with regard to the definition of the "Primary Health Care", and its concept is still evolving. Undoubtedly, the primary health care approach is a part of the overall health care system, and the connotation of its concept is based on the assumption that there exists secondary and tertiary health care.

The World Health Organization (WHO) has adopted the following definition to the Primary Health Care, "the primary health care is an integrated approach to meeting the need for better health of the people at the community level." It further states that primary health care, if successful, should be very simple and effective in terms of cost,

technique and organization, and improve health and living conditions of an individual, his family and community as a whole, by making available to everyone basic health care services. Noted below are some of the features of this primary health care.

1) Health Care Achieved through Simple Care at Community Level

The area of health care has thus far been with regard to the community residents as a group of passive recipients, and efforts have never been adequately made in eliciting the community's active participation or initiative in the program. Consequently, the problems and issues of health care until now were left totally to the realm of the professionalized social system.

However, the issue of national health care has come to the point where such professional health care systems cannot handle it alone. Thus, the system and for greater involvement of the community has arisen Primary health care is to satisfy the most basic needs for the protection of health. It can be compared to the lowest part of the pyramid of a comprehensive health care system. The health care, no matter how simple it is, would be undoubtedly effective in promoting health if it is universally made available to everybody. Furthermore, it will certainly reduce the health care efforts of higher level care. It is often said that approximately ninety per cent of the demand for the health care in a community falls under the sphere of the primary health care activities.

2) Integrated Approach to Improve Living as well as Health Conditions of a Community

There can be no argument with respect to the view that "health" is a natural and social phenomena. It is self-evident that persons, unemployed and poor, cannot remain healthy, and that those suffering from ill-health are not able to lead normal daily activities. Good health is a tool to stop this vicious cycle. An approach which deals in an integrated manner with all the elements existing in the process of this vicious cycle is therefore desirable in effectively overcoming the problems at the rural community level.

Although the community inhabitants are fully aware of the interactions between health and living status, they tend to give more priority on the betterment of living conditions than on better health. Therefore any program, if it intends to deal comprehensively with such interacting problems, would receive much better response from the people than one that attempts to solve only the health issue.

The seminar held under the auspieces of KHDI is September, 1977, labeled the primary health care as follows:

(1) Primary health care is the basic health care unit and function of a nation-wide comprehensive health care delivery system;

(2) Primary health care is an activity that is achieved through active participation of the people and the health workers within various community units (including family, natural village and administrative Ri);

(3) The basic activities consist of the self-initiated actions of a community unit (village and administrative Ri) and those of the public health agencies;

(4) Since the health care activities should meet the basic health needs of the community, the emphasis should be placed more on the preventive aspect of the overall health care spectrum;

(5) Primary Health Care will be achieved through the teamwork of various health care workers (physicians, nurses and other health workers) and through the cooperation of non-professional village volunteer workers. Each health worker, except a village volunteer, must function to render minor curative, preventive and other related health care services; and

(6) It is desirable that the primary health care be made up as part of an overall community development program.

The primary health care, as defined herein, denotes a comprehensive activity that includes curative, preventive, promotive and rehabilitative services.

And yet there are a variety of problems remaining for us to solve. They include: community people's attitudes which are not very favourable toward the betterment of their health, considering the fact that the approach to the primary health care is not very effective; ambiguity in defining the jurisdiction of primary health care compared to that of a higher level of health service; problems arising from the professional-type professionalized jobs of non-professional workers such as CHP's; difficulty in rendering technical guidance and timely supervision; and the lack of the tools to study and assess the effectiveness of services delivered. With the given situation in Korea, it was often pointed out that a clear definition of the first contact care for the people needing that care is very important.

During the period of September 6-12, 1978, the First World Health Care Conference was held at Alma Ata, Russia, under the joint auspices of WHO and UNICEF. Representatives from some 140 countries took part in the conference. At the conference, it was reconfirmed that primary health care is a world-wide task. The Korean delegation, headed by the Minister of Health and Social Affairs, participated in this international forum.

The conference called for immediate and effective measures of the international, regional, and national levels in order to further primary health care throughout the world, especially in the developing countries, in cooperation with the newly emerging international economic order and through technical cooperation as proclaimed in the Alma Ata Declaration. Furthermore, the conference appealed to all the governments, international organizations such as WHO and UNICEF, multilateral or bilateral organizations, non-governmental organizational funds, all persons in health professions, and international societies, to extend full support to their national or international commitments made with regard to primary health care. It further called for expansion of the level of technological and financial support to developing countries.

Primary Health Care in Korea

Article 30 of the Constitutional Law of the Republic of Korea stipulates the following:

(1) All citizens shall be entitled to a decent human life;

(2) The State shall endeavour to promote social security; and

(3) Citizens who are incapable of earning a livelihood shall be protected by the State in accordance with the provision of law.

The Constitution further provides under Article 31 that, "All citizens shall be protected by the State for purity of marriage and health."

The Constitution is the fundamental law which sets forth the ultimate goal and direction that a nation strives for. All the national activities are performed and achieved under the principles and framework of the Constitutional Law. Articles 30 and 31 above clearly state that the health and medical care of citizens is one of the national goals. In materializing this Constitutional spirit, there may be various approaches.

With the basic goal of building a country of "healthy and high-spirited people", the government presently employs various policies

geared to the construction of a welfare society. It is already widely known throughout the world of the governments firm determination that it would take positive steps to widen and cement the national health infrastructure through organized, effecient services of field health workers, for the purpose of institutionalizing the primary health care system.

At the same time, accelerated efforts are being made to increase people's awareness of the primary health care through utilization of the mass media, as well as available community organizations such as the Saemaul Women's Association and field health workers.

In particular, one of the government's basic health care strategies is to equally distribute the national health care resources and to provide people in lower-income brackets with health and medical services. To achieve this strategy, the government will exert its efforts to establish an effective primary health care delivery system for the urban and rural poor, to improve maternal and child health and environmental sanitation, and to strengthen the activities in preventive medicine and public health.

As noted above, the primary health care approach and associated government measures are fully reflected in the national public health and the social development policies. Many experimental efforts have been made through this date to test whether this approach is feasible. The health care demonstration project currently under taken by KHDI is a good example of these attempts.

Function of New Health Workers

A system for health workers with whom a patient and his family make a first care contact varies from country to country in its contents. Their functions also differ greatly depending on each country's situation. The term "Health worker" has numerous definitions: medical assistant, nurse practitioner, health extension officer, public health assistant, family nurse practitioner, community health practitioner, medex, etc. Great contrast is also observed in its function and training curriculum. One thing common, however, is the fact that they are directly related to rendering primary health care.

Although not all countries in the world deal with primary health care at the national dimension, a good many countries have achieved considerable success in the primary health care program. Thailand, the philippines and Indonesia are among the Southeast Asian countries that introduced the primary health care system, and some ten African countries have benefited from this system. All the countries, advanced and developing alike, show an increasing interest in the system and place their national development priority on it. In the U.S.A., for example, the utilization of health workers is accepted as a highly

effective means of offering primary health care. Various reports indicate that the use of the system overcame the geographical disparity in delivering health care services, in saving medical costs, and in solving the problem of securing needed medical specialists.

The basic role of function of the primary health care worker is to actively and systematically take part in the maintenance and improvement of the health of the community members. Their roles can be generalized into three broad aspects as follows:

1) Aspect of preventive medicine:
Health consultations; improvement of environmental sanitation; and preventive care.

2) Aspect of medical treatment:
Minor treatment; first-aid treatment, and patient referral.

3) Aspect of guidance and extension services:
Improvement of health education and the leadership role in the community.

As mentioned earlier, the health personnel such as "Maul Geon-Gang Umoni - Village Health Club Member", "Community Health Aide", and "Community Health Practitioner" play key roles in the KHDI health care demonstration projects. Summarized below are their major activities.

1) Village Health Agent

They are the health agents who take care of health problems of the community residents at the village unit level. They are commissioned by the chief of the county (Gun) and are responsible for such activities as a disease prevention campaign, simple health care services, and patient guidance. They are appointed by the community members.

2) Community Health Aide

The community health aides are the government-appointed, multi-purpose health workers. Under the general supervision and direction of the community physician and community health practitioner, they perform multi-purpose activities, and assist in health and medical service deliveries at the Myon level. Their roles include pre- and post-natal care, vaccinations, assisting normal deliveries, identifying and controlling tuberculosis patients, administering simple drugs, treating minor wounds and diseases, providing family planning consultation, providing nutritional guidance, and undertaking health education.

3) Community Health Practitioner

The community health practitioner is in a nucleus role in the community health project, and meets health needs in the rural areas where no professional health-medical services are available. Among the activities performed by them are home visitations, physical check-ups, disease prevention, providing treatment with a physician's supervision, observing the conditions of a patient's disease and its development, patient referral, attending to deliveries, providing prenatal care, under-taking health education, recording medical and treatment histories, and the supervising and guiding of the activities of various health service programs.

In addition to these health care workers, the community physician plays a crucial role as well. The community physician is selected from among licensed medical doctors. He directs and supervises the health workers at all levels, takes full responsibility for the primary health care services, and performs such duties as referring patients to the secondary health care agencies and administering an overall health care service program in the community concerned.

WHO proposed a slogan, "Health for all by the Year 2,000". All the countries in the world are presently endeavouring to bring this slogan to reality. Conceivably, there may be many ways in meeting the goal envisaged in the WHO's slogan. By knowledge of the experiences of many countries, it was proven that the primary health care system is the most direct and effective approach among amny others.

On the other hand, increasing interest in the area of health service research has been noted among many in recent years. It is quite natural that the area of primary health care service is one of the important research subjects, but at the same time we should not overlook the fact that the health service delivery system, including medical treatment through hospitals, is also an important subject to be covered by the research effort.

KHDI plays outstanding roles in the areas of the primary health care and relevant health service research. In other words, KHDI has become an institute acknowledged by WHO for its exemplary performance in the Western Pacific region. KHDI was designated by WHO as its collaborating research institute in March, 1979. There is a strong probability that KHDI may grow as a focal point of the WPR/WHO Region in training health care personnel.

Needless to say, primary health care and the personnel engaged in this field will play an indispensible role in attaining the goal expressed in WHO's slogan, "Health for All by the Year 2,000". KHDI certainly added its share to the current world-wide efforts.

We sincerely hope that KHDI plays a role of the pioneer in national health program planning, both nominally and virtually, and grows as an essential institute which makes vital contributions to the formulation of national health policies.

Closing

The time has long gone by .. the time when the discussion of the definition of the primary health care and role of health workers was required and justified. Of course, nothing would be more pleasing, than if such a system and health workers were no longer required by us. But that is far from reality.

It would be wasted time if we devote ourselves to defining the primary health care and role of health workers. A more pressing question confronting us is how to institutionalize and maximize the utilization and the activities of such health personnel. We must realize that understanding, cooperation and active involvement of those in health and medical professions, as well as of the general public, are prepequisite to an early attainment of our goal.

B. Congratulatory Speech

by Dr. Seung Hahm Park
Vice Minister
Ministry of Health and Social Affairs

Your Honorable Mr. In-Shik, Kang, the governor of Cheju Province, Dr. E-Hyock Kwon, Chairman of the KHDI Board of Trustees, Mr. William E. Paupe, Representative of USAID, Dr. Rankin, Representative of WHO, Mr. McBain, Representative of UNICEF, ladies and gentlemen !

It is a great pleasure for me to deliver the congratulatory speech on the occasion of the workshop on the "Evaluation of New Health Workers", who played a vital role for the past three years in the KHDI health demonstration project financed under an AID Loan.

Through the ambitious and successful implementation of four Five Year Economic Development Plans, coupled with the strong political leadership of His Excellency the Late-President Park Chung Hee, Korea attained rapid economic growth unprecedented in history. With liberation from poverty which Korean people have accepted as their fate, Korea is now striving to bring about a highly industrialized-welfare society in the 1980's.

As it has been emphatically pointed out by the Late-President Park Chung Hee in many occasions, the social development and the promotion of welfare of the people are the major policy objectives on which the government places high priority.

Bringing about a welfare society is a long-cherished desire common to all the people in the world. We all know that the representatives of the member countries of WHO gathered at Alma Ata, Russia, in September 1978, in order to seek a way to achieve this very goal. The conference defined health as a basic human right. It also proclaimed throughout the world its determination that health care services of the highest quality should be made available for all the people by the year 2,000.

With the surprising progress in science and technology in recent years, we are able to send men to the moon. The science of medicine is no exception. Thanks to the development of new surgical techniques in kidney and heart transplantation and of the C.T. Scanner, etc., we are now able to save the lives of many once fatal patients, which was not dreamed of and an incredible feat even several years ago. Nonetheless, it is frequently observed that a great number of infants still lose their lives from tetanus, which could be prevented if simple knowledge and technology were applied in a timely manner. Many patients die helplessly at a hospital while their lives could be saved if their disease could be detected early enough and if simple preventive measures were provided to them.

As you are aware, we have many problems related to health care which are awaiting our prudent solution. Over-concentration of medical facilities and manpower in urban areas and geographical disparity in distribution of health and medical resources is one majoy problem. In order to solve these problems, the Korean government endeavors to expand its medical protection and insurance system to offer more tangible benefits to a wider portion of the population. However, it is annoying to witness a still greater portion of the population remaining beyong the reach of such benefits.

The health care demonstration project being implemented by KHDI at this critecal time with its view to finding solutions to these problems confronting us is considered to be a very timely undertaking. I sincerely hope that through this workshop, various problems encountered in the course of implementing the project shall be clearly identified, and that meaningful answers and a set of the recommendations which could be fully utilized in government policy-making are produced.

I would like to emphasize that the KHDI's health demonstration project is not the end of our efforts, but it is the start of ultimatly attaining a welfare society. The results of the demonstration project must be thus reflected in the national health care policy measures.

With this in mind, I would like to request all the health workers to exert their best efforts in bringing the project to a successful end, and furthermore, to bear in mind that health care programs of any nature do not exist for their own benefit but for the patients and for the better health of the entire population.

Lastly, I hope this four day workshop, though very short, will enable us to develop constructive national health care policies for Korea through in-depth discussions among all the participants gathered here today.

Hong Sung Chul
Minister, MOHSA

C. Congratulatory Speech

by Kang, Shin Ik
Governor of Cheju Province

Your Honorable Dr. Park Seung-Hahm, Vice Minister of Health and Social Affairs, Dr. Younghat Ryu, the President of the Korea Health Development Institute, ladies and gentlemen!

I am very happy to see that the first Workshop on Evaluation of New Health Workers is taking place on Cheju Island, with the participation of the distinguished foreign and Korean health policy developers and planners. On behalf of the residents of the Cheju Province, I wholeheartedly welcome all the participants who have devoted their mind and heart to the betterment of our national health.

As you are well aware, health is the source of happiness. It is the most fundamental hope and desire of a human being. It is for this reason that the government has invested an extra budgetary and administrative resources in the pursuit of an ideal welfare society which would free the people from the fear of pain and disease. Despite our continued efforts and desire, there are still many factors in our surroundings which deteriorate our health. In addition, rapid industrialization poses new problems, such as environmental pollution and resultant diseases which we must face and solve.

Newly emerged as an internationally renowned tourism site, Cheju Island is very vulnerable to the contagious diseases from the outside due to the heavy inflow of foreign and Korean tourists.

At the occasion when His Excellency, the Late-President Park Chung Hee visited our Island early last year part of his scheduled New Year Inspection tour, he expressed his deep concern over the fact that the Cheju islanders have long suffered from inconveniences due to the lack of medical facilities, and he instructed us to exert our best effort in expanding medical facilities, as well as in inducing the private practitioner to come from the mainland, to offer quality health medical care services to those needing them.

Inspired by President Park's special concern and the government's positive supports, epoch-making progress is being made in the expansion and modernization of the medical facilities on our island, and the local administrative resources, health workers of all levels, and other organizations associated with health are being fully mobilized to promote the health status of the inhabitants.

It is indeed of great significance that the Workshop is held at this crucial juncture, in order to have an interim evaluation of the new field health workers, with the attendance of distinguished health and medical disciplines from the central government agencies and related organization.

I sincerely hope that the gathering here today will renew our people's awareness of health and sanitation, and motivate us to build a healthy and happy welfare society in which no disease or pain exists.

I further hope that, during your short stay our Island, you will certainly see the real profile of the Cheju people who put a lot of themselves in to making our island a more beautiful and richer "New Cheju". I would appreciate if, as has been done before, you kindly give us your invaluable advice and suggestions to make this island into a paradise for tourism, which will remain free from environmental pollution and which provides vitality to all tourists, both foreign and Korean.

Lastly, I hope your stay will be pleasant, and wish you and your family the best of luck.

Thank you.

D. Congratulatory Address Given By Mr. William E. Paupe, AID Representative in Korea, on the Occasion of the Workshop on Evaluation of New Health Workers in Primary Health Care, at the KAL Hotel, Cheju City, on August 29, 1979

Mr. Minister, Governor Kang, Dr. Kwon, Dr. Ryu, distinguished participants and guests.

It is a distinct nonor and and a great personal pleasure for me to be given the opportunity to participate in this ceremony today.

The U.S. AID Mission in Korea is happy to be able to assist the Ministry of Health and Social Affairs and the Korea Health Development Institute to carry on this important workshop.

The U.S. Agency for Internation al Development is extremely proud to be a part of the Republic of Korea effort to develop an effective, efficient and appropriate low-cost primary health care delivery system, -- which seeks to utilize appropriately trained health workers to deliver health care services to needy people in the more remote rural areas.

As you no doubt know, all over the developing world, AID has for many years been experimenting with methodologies designed to insure the more improved delivery of health services.

We have seen some successes, and unfortunately, too many failures. It is my belief that the majority of the failures can be attributed to the absence of one or several of the following important ingredients necessary to develop a successful delivery system:

1. Careful selection of the demonstration (or pilot) site.
2. Involvement of the local community to the maximum extent possible.
3. Obtaining local government support and commitment before the project starts.
4. Integration of existing health workers into the new delivery system.

The U.S. Agency for International Development is convinced that the KHDI primary Health Care Demonstration Project is a highly successful one because it has paid attention to each of these important elements. It is our hope that this evaluation, as well as the final project evaluation which will be carried out next year, will prove that this primary health care delivery system is the most efficient and effective approach to the provision of the health care needs of all the people in the Republic of Korea.

On behalf of the U.S. AID Mission in Korea, I would like to extend our most sincere congratulations to the Ministry of Health and Social Affairs, to the KHDI, and in particular to the local provincial, Gun and Myon government officials and to the CHP, CHA and VHA Health Workers for the outstanding accomplishments you have made to this day. In addition, we extend our warmest wishes for continuing success in your efforts to provide a more healthy and productive life for all your fellow citizens.

Thank you.

2. Paper Presentation

A. Training of Health Workers & Information Activities

1. Orientation pertaining to Training of Health Workers & Information Activities was conducted by Mr. Kilbyoung Yoone, Chief of Manpower Development Division, KHDI and the contents of the presentation is made up from the material in the 1978-1979 KHDI Report.

This information is exerted from pages 38-44 of that report.

Annex 1. Summary of Didactic-Hours.

Annex 2. Practical Examination-evaluation used by preceptors for Hospital practice.

Annex 3. Additional evaluation form used by preceptors for obstetrics of Hospital practice.

Annex 4. Evaluation form used by preceptors for laboratory fest of Hospital Practice.

Annex 5. Evaluation of CHP's performance of field practice.

3. TRAINING OF HEALTH WORKERS & INFORMATION ACTIVITIES

A. CHP TRAINING PROGRAM

On the basis of the US/Korea loan agreement, the Minister of Health and Social Affairs granted the authorization to train CHPs as new primary health care manpower for demonstration project of KHDI.

The detailed accounts of implementation is summarized hereunder in managing of the training program to develop and impart technical education-training in a limited time span, to instill competent skills, and to thus produce a multipurpose curative, promotive and preventive community health-service worker.

1) Main Functions of CHP

Their main functions are summarized as follows.

a) Curative services to:
- Delivery primary and ambulatory health care including home visiting
- Identify the most common disease
- Take general medical histories and perform physical examinations
- Provide treatment for a defined range of conditions
- Provide regular follow up of chronically ill patients
- Make efficient referrals of complicated cases

b) Preventive Services to:
- Provide pre and postnatal care
- Attend normal delivery
- Provide child health care including immunization
- Undertake health education
- Carry out family planning
- Control communicable disease: tuberculosis, venereal disease, etc.

c) Others, to:
- Plan and evaluate the health services activities
- Manage medical, health, and administrative supplies
- Educate and lead lower level health personnel
- Support and participate in the community agencies
- Supervise CHAs & VHAs
- Record & report data with accuracy

2) Selection Procedures

Personnel selection was thus an important step, therefore applicants were screened on the basis of applicant's personal career and many other factors with the documents submitted to KHDI by the Gun Health Care

Steering Committee. Preference was given to native residents of the pilot demonstration areas, with first priority going to qualified nurses of college graduate already working in the area.

Upon the recommendation of the provincial and county governor, KHDI conducted the examinations and interviews in terms of health knowledge, skill in technical areas and personal characteristics.

At the end of the examination and interviews, a total of 25 CHPs (11 from Hongchon, 9 from Okgu and 5 from Gunee) were selected on July 2nd, 1977.

3) Training Schedule

The community health practitioner training program lasted approximately twelve months. The one year training course was separated into 3 months classroom training, 3 months clinical practice and 6 months field practice. The classroom training (including orientation) was carried out in KHDI Headquarters. The clinical practice was given at the referral hospitals located in or near each demonstration area.

Field practice training in practical primary care and communicable disease prevention was carried out at the community health centers and pirmary health units in the demonstration areas. The training program was actually divided into four phases; orientation, theoretical classroom education, clinical practice and field practice.

4) Curriculum Content

a. Orientation phase

The initial two-weeks orientation lectures covered the following main subjects: Introduction to KHDI project and policy, Community organization and evelopment method, Role of CHP in demonstration area, How to conduct community survey, Recording and filling system, How to supervise health workers, Emergency treatment, Field observation of demonstration project and Case discussion, Group study regarding Korean rural health problems.

Heavy emphasis was placed on professional attitude, human relations and understanding of community structure involved with the demonstration project.

b. Theoretical phases

Insteay of conducting theoretical instruction for all 25 trainees simultaneously, the group was divided into two group, A and B. A batch was given classroom instruction followed by field exposure, while for B batch the process was reversed. A 10 week (330 hours) skill-phased training was conducted on core skills and practical procedures to assess and diagnose the most common diseases of patients.

to take general medical histories, and to provide public health education

The allocation of time for designated areas was as follows:

Related community health maintenance	21%
Community involvement and others	9%
Health data collection and assessment	12%
Management of health and illness	44%
Discussion, group work and tests	14%

Six volumes of text materials were developed by various internal and external instructors in a modular approach and used for instruction in class and later reference during clinical and field practices. During this phase, the trainees were required to gain understanding of, and increase competence in data collection with analysis and synopsis of patients, pathological processes related to common-primary manifestation thereupon.

c. Clinical Practice

Clinical practice was the second phase of CHP training and was a continual part of preceptorship or internship. It directly followed the theoretical phase of training and lasted for 3 months.

The primary educational goal of the preceptorship was to learn to diagnose and manage commonly encountered acute, chronic, emergent symptoms and health maintenance care problems.

Additionally, it is aimed to continue expanding the knowledge and skills learned during the theoretical phase. Trainees are rotated as scheduled through such departments as medicine, surgery, OB/GY, pediatrics, emergency room, dermatology, laboratory, and pharmacy.

The basic framework for the CHP trainees in caring for a patient is as follows.

- History taking, physical examination
- Treatment plan, including diagnostic studies, medication to be ordered or continued other specific treatments
- Teaching, counseling, referrals, follow-up

d. Field Practice Experience

The field practice for 24 weeks was carried out on the job situation in each demonstration area.

The principal objective of this field practice was to provide the trainees with an opportunity for actual field experience in rural communities where the majority of the community receive medicare and much services. In addition they received practice in supervising CHAs and conducting preventive and educational campaigns.

The CHPs were encouraged to involve themselves as much as possible to various local social-community sponsored meetings during their stay in the assigned area.

To facilitate the CHPs activities and to solve problems encountered in the field an officer of KHDI remained in the field full time to provide guidance and supervision. Also three Medical Doctor-Supervisor of KHDI visited the CHPs in the field on a regular basis to instruct and supervise.

e. Evaluation and Final Results.

All the trainees underwent approximately 3 tests of all theoretical subjects during the 3 months classroom instruction and 3 separate evaluations on clinical and field experiences with forms developed for preceptors, county health center director (as field practice evaluator), KHDI trainers, field supervisory trainer doctors and self-evaluation.

The aggregate results of each trainee was analyzed and presented to KHDI's Scholastic Assessment Committee for the final review and approval. The committee recommended to the President of KHDI through assessment of the trainees' work those who should be passed, or be failed. The average age of CHPs was 27.8 years with a range of 23-45 years, and the average duration of their experience in the field of health was 4.4 years with a range of 1-18 years.

The per capita cost of CHP training appears to be rather expensive for it is an initial experimentation project which requires a large capital investment for various training materials, modular texts, honoraria and training supplies.

The unit cost of CHP "A" batch (the first trainee group) was reduced to $1,450. It will be quite safe to assume that the projected estimation of the unit cost per trained CHP will be around $1,000 or less, when the training is conducted at a later stage by an institutionalized system.

B. CHA TRAINING PROGRAM

Community Health Aides (CHA) are at the 3rd level of worker's service line in the health delivery system of "Maul Geongang Saup". These aides are drawn primarily from the ranks of the present single purpose workers in family planning, tuberculosis control, and maternal and child health service, who are currently assigned to carry out their activities at the Myon office or health sub-center. Formerly, each of these workers had one assigned area of the job and covered an entire Myon. They receive an additional training with our project in this training stage and are re-directed to provide the innovative services regarding "Maul Geongang Saup". They will perform various functions under the guidance of the Community Physicians and Community Health Practitioners.

1) Main Functions of CHA

a. Provide ante and post natal care including assisting at normal deliveries.
b. Provide first aid.
c. Administer immunization.
d. Conduct health education including sanitation for VHA and residents.
e. Assist family planning services such as dispensing pills or condoms.

f. Undertake identification and control of tuberculosis patients.
g. Collect vital statistics and to record other necessary data.
h. Supervise VHA.

2) Training Program

The 8 week training course was divided into 3 phases: 2 weeks classroom education, 2 weeks clinical practice and 4 weeks field practice. A total of 30 CHAs selected from 3 demonstration areas (6 from Hongchon, 11 from Gunee, 13 from Okgu) reveived the 8 weeks course for multipurpose activities.

The classroom training of the first course for 30 CHAs from 3 demonstration areas was conducted at the nursing school in Kyung Buk Medical College, Taegu city, in July 1977. Also, field observation were completed at the existing demonstration project area in Yongin Gun, Kyonggi-Do for a week. Clinical practice training was carried out in three referral hospitals near the demonstration areas. Finally, field practice for the first CHA training was conducted under guidance or supervision of a physician and CHP at each Gun health center, community health center, and primary health unit.

The second CHA training was given to 25 CHAs who were assigned to their service settings in Gunee Gun through May to September 1978.

The third training course for 24 CHPs who are assigned in Hongchon Gun was conducted at the Farmers Training School and health center on the facilities in Hongchon Gun through June to October 1978.

The fourth CHA training was given to 33 CHAs who were assigned to their service settings in Okgu Gun through September to November 1978.

3) Curriculum Content

The purpose of the program of the instruction is to provide the CHA with the necessary knowledge and skill in the three main fields of TB,MCH and FP, as well as emergency care, sanitation and health education for the residents in the rural area. Allocation of time and curriculum for CHA training areas was as follows:

a. Classroom theoretical education: 2 weeks (84)

a)	Development of service attitude	8%
b)	Health education	19%
c)	Maternal & child health	31%
d)	Family planning	17%
e)	Tuberculosis control	17%
f)	First aid	8%

b. Clinical practice: 2 weeks (88)

a) Activities in clinic
b) Disinfection & sterilization of medical instruments
c) Contact & management of patient
d) Keeping & management of drugs

c. Field practice: 4 weeks (176)
   a) Home visiting for MCH care, FP services, TB control and case finding
   b) Health education
   c) Participation of the community
   d) Vaccination
   e) Reporting & recording

In the first CHA training, the instructors for CHAs were made available from Kyung Buk Medical & Nursing Colleges, institutes, hospitals and rural health authorities concerned such as the Health Division of Kyung Buk Province, TB Association, etc. They served as parttime instructors in their special subjects in the classroom education.

In the second CHA training, a few personnel from health authorities and centers concerned joined in the 2 weeks classroom training as instructors and most of the subjects for the training were covered by KHDI trainers, staff of the Gun health center and CHPs.

In order to provide efficient training, an orientation session for instructors and supervisors was conducted, and contents of the orientation session for instructors was conducted, and contents of the orientation in general were in line with that of the CHP training.

4) Evaluation

Four times assessment was carried out during the 8 week CHA training; a pretest and final test were conducted during the theoretical phase, and skill in the clinical phase, and knowledge, skill and attitude in field practice phase.

The results of the achievement and assessments of each trainee were analyzed and presented to the KHDI Scholastic Assessment Committee. Their average age was 22.1 years with a range of 17-28 years, and the average time lengths of their experiences in health field was 2.2 years with a range of 6 months -14 years. The unit productive cost of the CHA training was estimated at approximately $244.

C. VHA TRAINING PROGRAM

The Village Health Agent (VHA) is a man or a woman who is literate and selected by the Myon Health Development Committee or other local authorities to cope with the general health problems of families in their villages communities.

They were appointed by the county (Gun) chief and supervised or assisted by the CHP and/or CHA and their services are strictly on a volunteer basis. The scope of their services and activities is strictly limited to what is instructed in line with the functions indicated below:

1) Main Functions of VHA

a)	Maternal care	- Assisting pre and post-natal care - Assisting delivery - Finding pregnant women and reporting them.
b)	Child health	- Infant feeding & weaning - Motivate mothers for immunization - Finding sick babies and reporting them
c)	Communicable disease	- Case finding & reporting - Dose drugs (diarrhea, fever, digestive)
d)	First aid	- Minor treatment using mercurochrom or hydrogen peroxide - Burns, wounds, fractures, bites - Bleeding control
e)	Referrals	- Refer to the upper levels
f)	Others	- Individual hygiene - Sanitation in household environment

2) Training

The classroom orientation for all VHAs is carried out at the Gun office or the Gun health center for 2-5 days. A 3-5 hours a day follow-up session is given monthly to the VHAs at the Gun health center so that the schedule allows them to commute every day. Additionally, the VHAs received a few hours field training in the health-service settings nearby the village.

An initial training of 5 days for 62 VHAs was conducted at the Farmers Training School in Hongchon (Gun) in 1977. The purpose was to give orientation in Maul Geongang Saup together with a clear understanding of their duties as volunteers. A 3 days' refresher training for 44 VHAs was conducted in November, 1978.

In Gunee Gun, a total of 99 VHAs were selected from villages in the pilot Myons and divided into 4 groups, taking into account geographical factors so as to allow for more effective training. A 2 days training was carried out at the village cultural center in 4 Myons respectively during the month of November and December 1977.

Also, 78 VHAs were selected from the expanded pilot Myons in 1978 and a 8 days training was carried out at the health center during the months of January and February 1978.

In Okgu Gun, approximately 260 VHAs were selected from the villages and appointed by the Gun Chief in July, 1978. One day orientation training for 220 VHAs was conducted at the cultural center in Taeya in August, 1978.

Instructors of the orientation training consisted of Gun health center staff, KHDI staff and personnel from related agencies or local authorities concerned.

Annex 1

Summary of Didactic Hours

1. Orientation phase training: 2 weeks/66

Subjects	Hours
Introduction to Maul Geon Gang Saup	3
Health care delivery system in Korea/Abroad	3
Observation tour to existing health demonstration project	12
Introduction to community health	2
Community survey	2
Introduction to health need	2
Health center administration	3
Medical insurance scheme	3
Yoo Shin philosophy and Saemaul movement	3
Social development and health services	4
Community development and health-related resources utilization	6
Role and function of CHP	3
Supervision of health workers	4
Report and record keeping	6
Introduction to module approach	6
Others including pretest and final test with short resume	4

2. Theoretical phase training: 10 weeks/330

	Subjects	Hours
A.	Community health related	46
	Communicable disease control including tuberculosis	12
	Health education	10
	School health	3
	Nutrition	8
	Environmental sanitation	7
	Vital statistics	6
B.	Community development	23
	Group dynamics	9
	Counseling Techniques	6
	Organization of health resources and community agencies	8
C.	Core skills	47
	History taking	11
	Physical examination	20
	Laboratory	15
D.	Management of health illness	175
	Medical problems including	49
	- Respiratory	
	- Gastrointestinal	
	- Cardiovascular	

- Neurological
- Genitourinary
- Dermatology
- Psychiatric

Surgical problems including

- General surgery
- Orthopedics
- Eye ear nose throat
- Dental

Maternal and child health

Emergency care

Use of drugs and management

3. Clinical practice phase: 12 weeks/456

Weeks

Medicine 3-4 weeks

Surgery 1 week

Ob-Gyn 3 weeks

Pediatrics 1-2 weeks

Emergency care 1-2 weeks

Laboratory 1 week

Annex 2.

Practical Examination-Evaluation used by preceptors for Hospital Practice

Scoring:
superior-5
above average-4
satisfactory-3
marginal-2
unsatisfactory-1

Preceptor:
Name of trainee:
Date:

1. History taking

	5	4	3	2	1
(1) chief complaints					
(2) present illness					
(3) past history					
(4) general physical condition					
(5) family history					

2. Physical Examination

A. Technique

	5	4	3	2	1
(1) vital sign					
(2) head					
(3) ears, eye, nose, neck					
(4) chest & breast (percussion, auscultation nodes, others)					
(5) abdomen-percussion of liver and spleen					
(6) nodes					
(7) back-spinal tenderness					

	5	4	3	2	1
(8) genitourinary					
(9) extremities					
(10) skin					

B. Organization & use of instruments

(1) well organized					
(2) use of instrument					

3. Plans

A. Diagnostic

(1) appropriateness of diagnotic plans					
(2) appropriate use of drugs					

4. Patient education

(1) counseling techniques					
(2) follow-up					

5. Other comments

Annex 3.

Additional evaluation form used by preceptors for obstetrics of Hospital Practice

Scoring:
Superior - 5
Above average - 4
Satisfactory - 3
Marginal - 2
Unsatisfactory - 2

Preceptor _____

Name of Trainee _____

Date 1978 _____

Areas	5	4	3	2	1
1. Prenatal care skill					
2. Normal delivery skill					
3. Management skill for Gynecological patient					
4. IUD insertion					
5. Preparation for instruments and using skill					
6. Other comments:					

Annex 4.

Evaluation form used by Preceptors for Laboratory test of Hospital Practice

Scoring
Superior 5
Above average 4
Satisfactory 3
Marginal 2
Unsatistfactory 1.

Preceptor _____

Name of Trainee _____

Date 1978 _____

Areas	5	4	3	2	1
1. Use of microscope					
2. Specimen collection					
3. Hematologic examination					
4. Urine examination					
5. Stool examination					
6. Other comments:					

Annex 5.

Evaluation of CHP's Performance of Field Practice

Scoring
Superior 5
Above average 4
Satisfactory 3
Marginal 2
Unsatisfactory 1

Name of Trainee _____

Unit of Practice _____

County _____

I. Medical care

	5	4	3	2	1
A. History taking					
1) interview and counseling					
2) chief complaints & present illness					
3) past history & family history					
4) record findings accurately					
B. Physical Examination					
1) appropriateness to complaints					
2) perform procedures systematically					
3) correctly uses the techniques of inspection, palpation, percussion and auscultation					
4) maintains privacy for the individual during all aspects of the examination					
5) correctly uses the instruments					
6) records findings accurately					

	5	4	3	2	1
C. Diagnostic tests					
1) adequately prepares the individual and matters related					
2) urinalysis					
D. Decision making and clinical management					
1) identification of normal & abnormal condition					
2) requests appropriate lab and diagnostic test					
3) effective treatment plan					
4) records findings accurately					
5) referral of patient to appropriate level					
E. Medication					
1) accurate drug selection					
2) explains about taking medicine					
3) drug management and preservation					
F. Education and Counseling					
1) appropriate education and counseling regarding Pt' treatment					
2) counseling with individuals regarding nutrition, personal hygiene, family health care					

II. Preventive Care

	5	4	3	2	1
A. Maternal care					
1) accurate preparation for antenatal					
2) accurate examination and test					
3) education about nutrition, health maintenance and delivery					
4) adequate techniques- of normal delivery					
B. Child care					
1) health assessment, teaching and couseling					
2) feeding and weaning					
3) immunization					
C. Family planning					
1) preparation for IUD insertion					
2) adequate techniques with IUD insertion					
3) counseling					
4) referrals in the administration					

	5	4	3	2	1
D. Environmental sanitation					
1) keeping of sanitation maps					
2) participating in sanitation improvement activities (test and chlorination of drinking water)					
3) education on improving the latrine conditions					
4) education on waste and refuse disposal					
III. Administration					
1) planning monthly work program					
2) management of supplies					
3) keeping of administrative documents up to date					
4) keeping of health-related records up to date					
5) supervision of health workers					
6) orientation to new health workers					
IV. Participation with community activities and relationship					
1) winning patient's confidence					
2) good working relations with health workers					
3) CHP/nursing professional interaction					
4) acceptance by health officers in assigned area					
5) get along well with doctors in assigned area					
6) relates well in community affairs					

B. Functions and Role of Primary Health Care (Maul-Geon-Gang-Saup) Workers

by Lee, Sung-Woo
Director, Health Project Division

1) Outline of the KHDI Health Demonstration Project

Before the functions and roles of new health workers are touched upon, it may be worth while to explain the current deployment status of health workers in three demonstration project sites (KHDI's Maul-Geong-Gang-Saup -- Community Health Project). Deployment of health workers has been somewhat different in these three areas of Hongchon Gun, Gangwon Province; Gunee Gun, Gyeongsan Buk Province; and Okgu Gun, Cholla Buk Province.

1-1. Hongchon Gun Maul-Geong-Gang-Saup

The Maul-Geong-Gang-Saup for Hongchon Gun is restructuring the health services system at the Myon level for the delivery of primary health care services. A three-tiered service and referral system for primary health care was introduced, with an emphasis on the Village Health Workers at the grass roots level, participating in the delivery of first-contact health care services.

The Community Health Practitioners, who have completed their one year of training by KHDI, are providing primary phase health care to the people in remote villages. The physician already existing in each Myon is acting as the Community Physician and takes care of the patients at the Myon and those referred by the Community Health Practitioners.

The first level of care is rendered by Village Health Agents at the village level. These Village Health Agents at the village level. These Village Health Agents are selected by the village people and trained by local health centers so as to provide simple drug-supply and teach preventive measures under the guidance and direction of the Community Health Practitioners. They refer cases to the subsequent level of the system, the Primary Health Unit, or directly to the Community Health Center.

The services of primary health care are provided by a Community Health Practitioner with limited medical care and preventive health service to the patients and people in several villages, and they, the CHP also supervise the activities of Village Health Agents in those villages. When the Community Health Practitioners cannot handle the patients within their limited capacity, the patient is referred to the Community physician at the community Health Center.

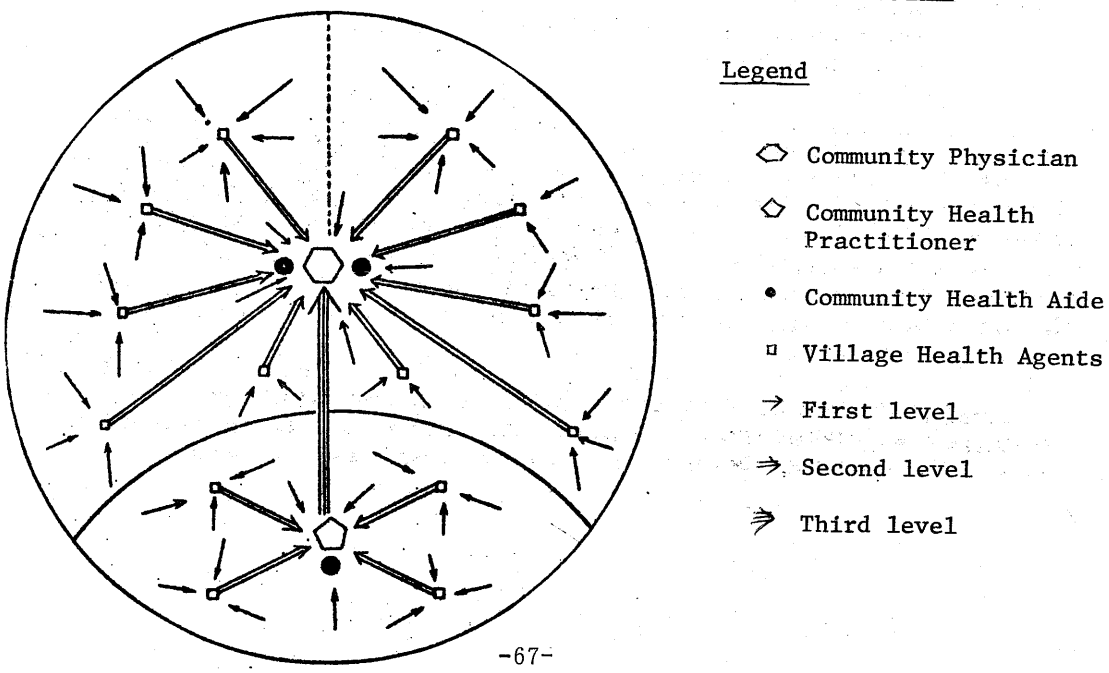
The second level of care is provided by the existing physician in each Myon at the Community Health Center. This physician is designated as a Community Physician, and is responsible for the medical care of the population in the whole Myon and supervision of the activities of the Primary Health Unit staffed by a Community Health Practitioner.

Three Community Health Aides (health workers) existing at a Myon level, are trained for multipurpose work by KHDI and reassigned to a Primary Health Unit. They assist the Physicians and Community Health Practitioners in providing health care and the multipurpose health service in their areas.

Table 1. Level of Services in Hongchon Gun

Level	Health Worker	Facilities	Population Served
First	Village Health Agent	Village Health Post	Ri & Villages 500 - 1,000
Second	Community Health Practitioner	Primary Health Unit	Sub-Myon (several Ris) 3,000-5,000
Third	Community Physician	Community Health Center	Myon 10,000 - 15,000

Figure 1. Primary Health Care Delivery System in Hongchon Gun



1-2. Gunee Gun Maul-Geong-Gang-Saup

In Gunee Gun, a three-tiered health care system with the main emphasis on the improvement of maternal and child health services has been introduced. In this Gun, three Community Physicians were newly recruited and assigned to head the Community Health Centers and one Community Health Practitioner is assigned to each Myon where there is no physician. Besides these two categories of health personnel, one nurse-midwife for each Myon is newly employed to head the Primary Health Post.

The health delivery system at each level is organized as shown in Table 2 below.

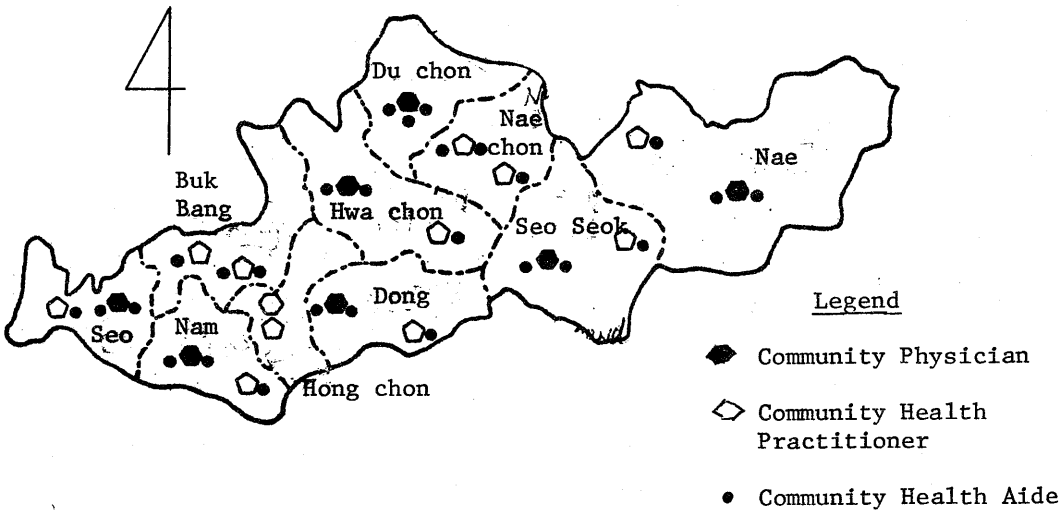
Table 2. Level of Health Services in Gunee Gun

Level	Health Worker	Facilities	Population served
First	Nurse-Midwife and 1-Community Health aide	Primary Health Post	2,000-3,000
Second	Community Health Practitioner and 2-Community Health Aides	Primary Health Unit	6,000-8,000
Third	Community Physician and 2-Community Health Aides	Community Healther Center	20,000-25,000

The first level of primary health care contact is provided at the multi-village level Primary Health Post, serving a Community of about 2,000 to 3,000. A nurse-midwife and one Community Health Aide are assigned at the Primary Health Post. The nurse-midwife provides emergency care, first aid, and midwifery services and, the Community Health Aide does the multipurpose preventive health services at the village level.

The second phase of primary health care is provided at the Myon level with a Community Health Practitioner and two Community Health Aides. The Community Health Practitioner is responsible for primary

Figure 2. Distribution of Maul-Geong-Gang-Saup Personnel in Hongchon Gun



health care for the inhabitants and those referred from the Primary Health Posts. Two Community Health Aides carry out the multipurpose preventive health service for one-third of the Myon's coverage. The patients whom the Community Health Practitioner cannot handle are referred to the third level Community Health Center which is located in an adjacent Myon.

The third level of health care is provided by the Community Physician at the Community Health Center, each one covering two to three Myons. The Community Physician at the Community Health Center is responsible for the supervision of Primary Health Units and Primary Health Posts in the area.

At the village level, one Village Health Worker health communicator from each village was selected and given three days of orientation training for the project. These village Health Workers are going to assist the Community Health Aides when they visit the village and at the same time act as health communicators for the village.

At the Gun health center, to facilitate the project activities, one health educator, one sanitarian, one sanitarian, one statistical officer, and one dental health worker were newly recruited by the project and added to the health center staff.

Figure 3. Primary Health Care Delivery System in Gunee Gun

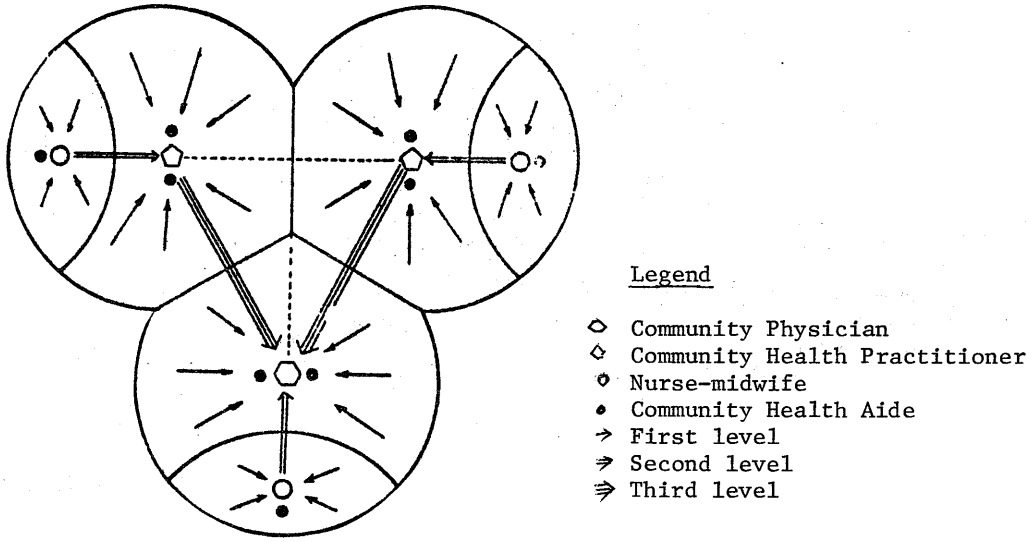
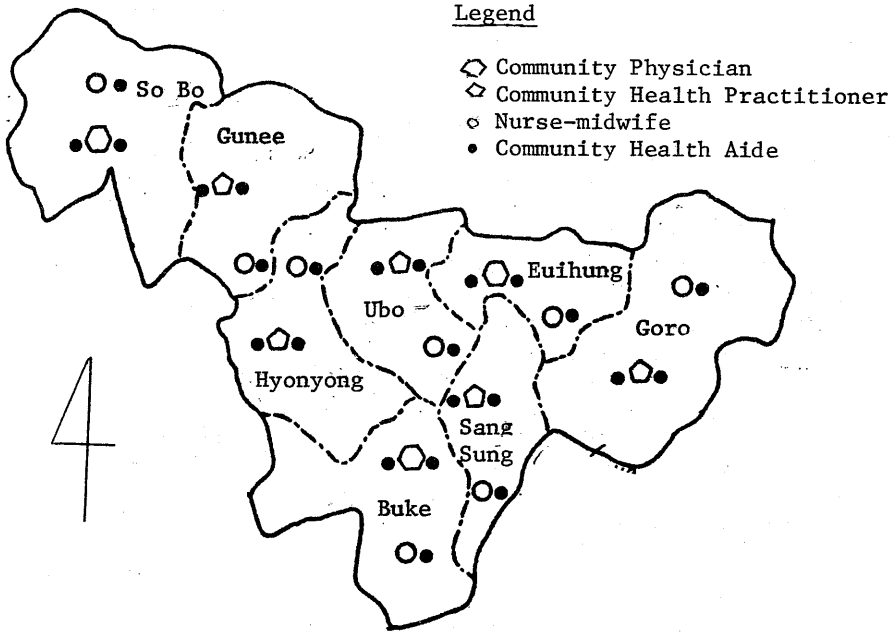


Figure 4. Distribution of Maul-Geong-Gang-Saup Personnel, Gunee Gun



1-3. Okgu Gun Maul-Geong-Gang-Saup

In Okgu Gun, with a minor structural modification of the existing health center and subcenters, health care services are delivered to the population by the development of such a medical insurance system as can be afforded by the Government. Since this Gun has many inhabited islands scattered along the Yellow Sea, a number of Community Health Aides are deployed to islands to provide the primary health care with the assistance of Community Health Practitioners on a bigger island in the vicinity.

Okgu Gun Maul-Geong-Gang-Saup is divided into two different demonstration areas -- mainland and islands. For the mainland, four Community Health Centers are established, each one serving two Myons. One qualitied full-time physician designated as the Community Physician, runs the Community Health Center with one Community Health Practitioner posted at an Outreach Clinic in the adjacent Myon. This Community Health Practitioner serves the people in the adjacent Myon in primary care and refers those patients who require further consultation or treatment to a larger Community Health Center. Three Community Health Aides are utlized as multipurpose health workers, each one serving one-third of a Myon under the direct supervision of the Community Physician or the Community Health Practitioner. One additional Community Health Aide is newly recruited to assist the clinic activities of the Community Physician or the Community Health Practitioner.

On the islands, one Community Health Center with a qualified physician is established on Sonyu Island. For island with a population of less than 700, one Community Health Aide is assigned to serve the islanders. Patients from these islands will be referred to the Hospital operated by the Guns and the Provincial Hospital to cover these islands.

Figure 5. Primary Health Care Delivery System in Okgu Gun

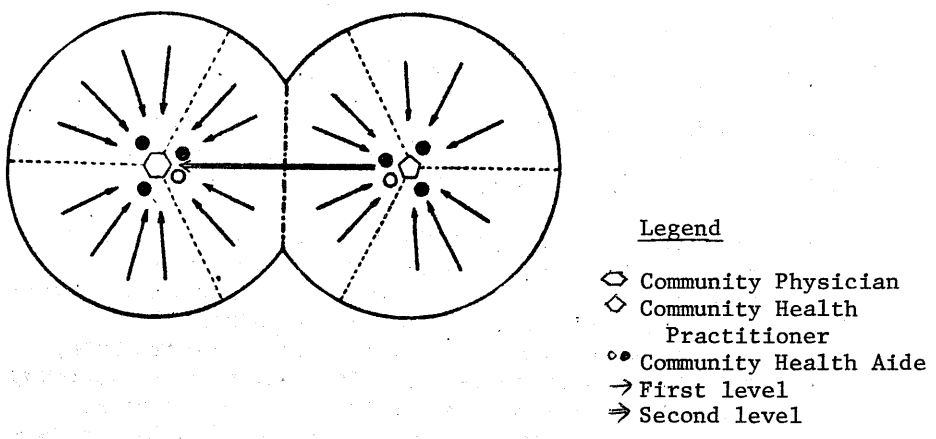
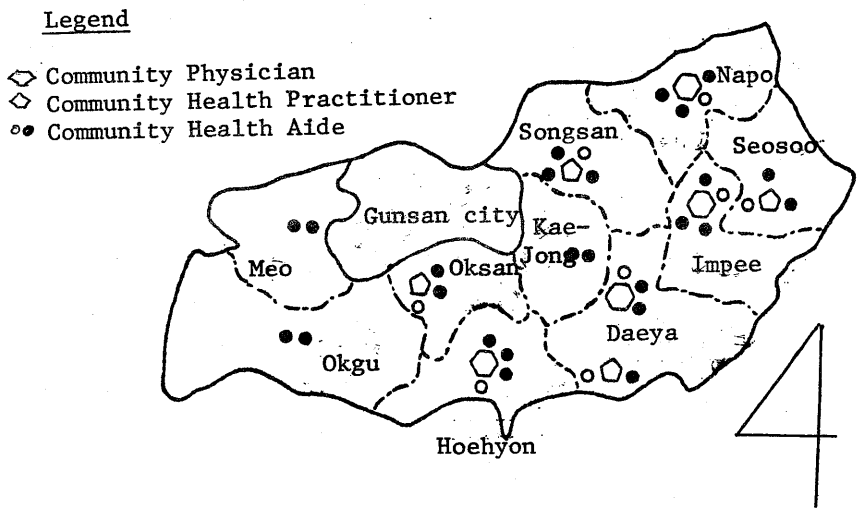


Figure 6. Distribution of Maul-Geon-Gang-Saup Personnel in Okgu Gun



2. Roles and Functions of Community Health Practitioner

Unlike the medex, nurse practitioner and medical assistant in U.S.A., whose function is to assist physicians in serving patients when physicians are too busy to handle all the patients, the Community Health Practitioner is a new health worker developed and trained so as to independently provide primary health care services to the people in areas without doctors. The Community Health Practitioner performs a wide-range of activities, such as health control of the residents, health and enlightenment education, supervision over other health workers assigned to Primary Health Units, active involvement in the community development programs, and improvement of living and environments status in the rural area. Major duties of the Community Health Practitioner can be summarized as follows:

2-1. Curative Services

The Community Health Practitioner independently provides the general medical care and curative services to the patients visiting the Primary Health Unit as listed below:

a. Examine patients, take their medical histories, perform auscultatory and percussionary examinations;
b. Measure a patient's vital signs and make an assessment thereof;
c. Diagnose diseases to the extent possible;
d. Collect blood for tests, and perform venipuncture;
e. Administer subcutaneous and intramuscular injections;
f. Fix splints in the case of fractures or sprains;
g. Administer suturing and blood vessel ligation in case of bleeding caused by an external wound;

h. Conduct surgical incision for the elimination of pus, where no anesthesia is necessary.
i. Cotton plugging in case of nasal bleeding;
j. Stomach catheterization in case of poisoning;
k. Micturition by inserting catheter in case of dysuria;
l. Prescribe drugs/medicine as listed in the attached table.

2-2. Patient Referral Services

The Community Health Practitioner refers the patients with any of the following symptoms to the Community Health Center or hospital in the vicinity.

a. Patients whose cases are beyond her skill or ability.
b. Patients in need of immediate surgery;
c. Patients who are likely to be suffering from a bone fracture, damage to internal organs or brain damage due to an accident;
d. Patients with symptoms suggesting the possibility of peritonitis;
e. Patients in need of a blood transfusion due to excessive blood loss;
f. Patients having breathing difficulty or who are unconscious, possibly because of poisoning;
g. Patients having injury to the spinal column or chest;
h. Hypertension with complications;
i. Patients who are not cured after seven days of treatment and medicine.

2-3. Pathological Tests and Preparation

a. Blood Test

Collection and delivery of speciman for such tests as ESR, hemoglobin, hematocrit, red and white blood cell counts, blood type and VDRL.

b. Urine Test

Urinalysis for the detection of sugar, protein, PH and urine specific gravity using a urinometer.

c. Stool Test

Test for parasite eggs.

d. Prepare smears for secretion from nose, throat, and male and female reproductive organs.

e. Rectal swabbing for bacteriological culture.

2-4. Maternal and Child Health

a. Pre-natal Care

1) Early detection of pregnancy and registration;
2) History-taking, physical examination and counseling.

b. Delivery attendance.
c. Conducting group health education on safe delivery procedures;
d. Providing post-natal care;
e. New-born care

1) Providing regular periodic counseling and evaluating health conditions of new-born babies through the baby clinic;
2) Providing guidance on a weaning diet
3) Confirm target dates for vaccinations, checking of general health conditions, for new borns, and give advice on possible complications which may follow after the vaccination.

2-5. Family Planning

a. Identify fertile women in the villages;
b. IUD insertion;
c. Providing follow-up care should problems arise;
d. Planning, directing and supervising family planning programs;
e. Conducting health education to enlighten people in family planning.

2-6. Tuberculosis Control

a. Providing follow-up care to those who are reluctant taking medicines and to problem patients;
b. Planning, directing and supervising tuberculosis control programs;
c. Conducting health education for the early detection of patients and keep a register of patient care.

2-7. Preventive Services

a. Taking appropriate measures according to prescribed prevention methods where communicable diseases occur, and conducting epidemiological studies;
b. Planning and administering various vaccinations;
c. Conducting health education to enlighten the residents about disease prevention;
d. Conducting environmental sanitation improvement programs, which includes:

1) Undertaking of education on the preservation, supply and use of drinking water;
2) Conducting education on chlorine sterilization of wells and simple water supply systems, and checking whether sterilization has been achieved;
3) Collecting, keeping and delivering specimens of drinking water for lab-tests;
4) Educating residents in the use of toilet screens and lids;
5) Educating residents in the use of sanitary kitchens & food preservation;
6) Conducting orientation on the care and disposal of trash, livestock waste, and sewage;

e. Identifying disabled people in the villages and providing counseling to them.

2-8. Administrative Work

a. Participating in the planning, implementation and evaluation of the health care programs.
b. Preparing and organizing an operational plan for clinic activities and Primary Health Unit activities;
c. Preparing weekly and monthly activity plans, and providing implementation;
d. Conducting periodic evaluations of the Primary Health Unit and Post activities and taking remedial measures for and problems which are identified;
e. Conducting an orientation program for newly recruited health workers, and planning and undertaking supplemental education for existing health personnel;
f. Requesting and receiving equipment and medical supplies for Primary Health Units;
g. Conducting periodic guidance and supervision for Community Health Aides and Village Health Workers;
h. Recording and reporting various data as well as keeping report forms and files;
i. Supporting and participating in health-related meetings and development gatherings held by public or private organizations;
j. Taking charge of financial management, and reporting on the revenues received from curative and preventive health care services.

3. Roles of the Community Health Aides

Community Health Aides, each one covering several Rees within the project area, provide multipurpose health work to the residents within their residents within their respective jurisdictions. They contribute to the promotion of home and community health through carrying out integrated health care activities.

3-1. Identifying the status of households within the area, and preparing a monthly activity plan.

a. Keeping at all times an up-dated report of the health status of Rees, Dongs and households within the area according to the family health file prepared by each household;
b. Preparing a monthly home visitation plan for each Ree and Dong, and make sure of its implementation;
c. Preparing, in detail, the activities to be performed at home visits the day prior to the scheduled visit, i.e., target group to be contacted, types of health services to be rendered, and other necessary matters.

3-2. Identification of Family Health Needs

a. Identifying each family's health care needs and problems through the use of the family health record files, and providing follow-up health care;
b. Keeping an up-dated health status file for each household member for entry into the family health files, and add up the information on individual health as well keeping abreast of the environmental sanitation.

3-3. Maternal and Child Health

a. Pre-natal Care

1) Locating pregnant women at an early stage of their pregnancy, and making registration;
2) Examining health conditions through diagnosis, such as measuring blood pressure and weight, and testing urine;
3) Making referral to the Community Health Practitioner or physician if any abnormality is detected.

b. Delivery Care

1) Distributing delivery kits to expectant mothers;
2) Teaching the use of the delivery kit and sterilization methods at home;
3) Providing delivery care and counseling;
4) Referring pregnant women to the Community Health Practitioner if any abnormality is detected.

c. Post-natal Care

1) Making home visits to provide post-natal care to those who gave birth at home;
2) Checking for any feeding problem, measuring postpartum discharges, and checking to see if there is any hemorrhaging;

3) Providing nutrition and nursing counseling and guidance;
4) Referring nursing mothers to a physician or Community Health Practitioner if any abnormality is detected.

d. Infant Care

1) Making registration of all new-born babies;
2) Taking regular measurement of weight, providing feeding counseling, and checking growth and development status;
3) Introducting a weaning diet and methods;
4) Identifying target dates for vaccination of new borns, and administering vaccinations.

3-4. Family Planning

a. Identifying women in the fertile age group within the area through use of family health record file;
b. Making registration of fertile spouses and target family planning groups;
c. Distributing oral pills and condoms;
d. Identifying the target population for IUD's, vasectomies and tubal ligations;
e. Conducting health education to motivate residents for the acceptance of family planning programs.

3-5. Tuberculosis Control

a. Prescribing medicine for the positive and negative patients registered;
b. Providing follow-up care to the registered patients, collecting and sending sputum of probable tuberculosis patients with symptom;
c. Issuing the request for chest X-rays;
d. Providing guidance on the use of medicines and how to keep healthy;
e. Conducting follow-up care for those who are non-cooperative in taking medicines and providing care problem patients;
f. Collecting sputum from those needing further obervation;
g. Filing records of registered patients.

3-6. Preventive and Curative Services

a. Reporting to th e Community Health Center any Communicable disease occurances, and participating in taking appropriate preventive measures;
b. Administering various vaccinations;
c. Providing counseling services to visiting patients, checking their conditions and referring them to a higher-level institution for treatment, if necessary;
d. Providing minor first aid treatment;
e. Assisting in other activities of the Primary Health Units.

3-7. Records and Report

a. Updating and keeping various data related to the activities of health workers;
b. Receiving and recording the data on the on the village status, this data is supplied by Village Health Agents when they visit the villages;
c. Preparing and submitting activity reports on the basis of the records maintained.

3-8. Involvement in Community Development Activities

a. Making periodic visits to Village Health Agents to guide and supervise them in their village activities;
b. Promoting and supporting health programs by attending community meetings and Saemaul leaders' meetings, etc., which are held regularly.

4. Roles and Functions of Village Health Agents

The objective of Maul-Geong-Gang-Saup is to improve community welfare and health by means of inducting active participation of the community residents and by utilizing to the maximum extent possible the available resources in the community. To attain this objective, Village Health Agents, selected from villagers and trained locally, are assigned the duties to directly provide individuals in their villages with health care, including promotive and preventive services, and to refer them to the upper level institutions if needed. The scope of their duties are as indicated below:

4-1. Family Planning

a. Discovering the contraceptive method most preferred by women in the village;
b. Making the contraceptive method best suitable to them widely known, and encouraging them to accept the method;
c. Distributing oral pills and condoms supplied by the Community Health Aide to those needing them;
d. Informing the Community Health Practitioner or Community Health Aide of the villagers desiring either a contraceptive operation or loop insertion;
e. Follow-up observation for those who have undergone a contraceptive operation, and immediately notifying the Community Health Aide of any detected abnormality.

4-2. Maternal and Child Health

a. Identifying women whose menstruation has suddenly stopped, and referring them to the Community Health Aide to test for pregrancy;
b. Encouraging the pregnant women to receive periodic pre-natal examination;

c. Arranging for a Community Health Practitioner to attend to delivery care, or distributing the delivery kit supplied by the Community Health Aide;
d. Making home visits within seven days after birth to check post-natal development, and informing the Community Health Practitioner of any abnormality which may exist;
e. Arranging for the mother and he new-born to have regular medical check-ups at the Community Health Center during the four-week period immediately after birth;
f. Providing nutrition guidance for expecting and nursing mothers;
g. Encouraging mothers to take a monthly measurement of the new-born's weight and height to check growth;
h. Encouraging the use of a weaning diet beginning five months after birth;
i. Telling mothers the importance of having various vaccinations in a timely manner for their babies;

4-3. Tuberculosis Control

a. Locating villagers who are troubled with a bad cough for a considerable lenghth of time, who suffer from afternoon fever, or who have a great weight loss, and forwarding such information to Community Health Aides;
b. Assisting the Community Health Aides in collecting and sending to the Community Health Center the sputum of tuberculosis patients or those believed to be carriers;
c. Encouraging registered tuberculosis patients to take medicines in a timely manner, and informing them of the date set their next regular check-up.

4-4. Simple Treatment

a. Administering treatment for patients with minor problems in accordance with the guidelines of service;
b. Informing the Community Health Practitioner or Community Health Aide of any abnormality in the health status of villagers should early appropriate treatment be necessary;
c. Immediately informing the Community Health Center of any patients with a communicable disease symptom, and assisting in taking necessary preventive measures.

4-5. Vital Statistics

a. Informing the Community Health Aide of the date of death of villager if any;
b. Encouraging to complete the birth registration of new-born baby within 15 days after the birth, or making registration by proxy if necessary;
c. Informing the Community Health Center of the matters related to households transferred in or out.

4-6. Handle supplies

a. Acquainting himself thoroughfully with the use of drugs and equipment and supplies;
b. Submitting periodic request of drugs and sanitary goods to Community Health Center and Primary Health Units, whenever necessary.

4-7. Others

a. Attending the meetings held at Primary Health Units and Presenting activity reports before them;
b. Assisting Saemaul development projects;
c. Conduct enlightenment campaign regarding improvement of life, health and sanitation;
d. Enlightening the residents about environmental sanitations (examples; improvement of toilet and kitchen, and trash disposal, etc.)

C. Evaluation on Implementation of Primary Health Care Workers and Approach Methods

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1) The Concept of Evaluation

The World Health Organization (WHO) plans to issue a publication entitled, "The Guidelines for Health Programme Evaluation." The introduction in the Publication says that the evaluation is not a new idea, but on old concept as a mechanical means to judge success or failure of the project.

It is also said that at the present time, evaluation is a continuous process, not only in evaluating success or failure of projects, but also to revise and improve project activities in order to make that project more proper and effective. Furthermore, the publication says that evaluation needs unbiased and sound judgement. This judgement also demands a very careful analytical sense and a judging ability of high intelligence. It is also pointed out that a person with such abilities should be able to suggest useful ideas for persuasive conclusions and activities.

In short, evaluation is an indispensable part of the management cycle for better effectiveness of projects, and it is also a dynamic process for succeeding with plans and operations.

Reference: Various Definitions of Evaluation

- Evaluation is process to check whether the plan is being effectively conducted.
- Evaluation contributes to decision making of a plan by clarifying problems, identifying resources, and determining the purpose.
- Evaluation is a process which judges whether or not the described purpose is in accord with the activities of the project. In this process, a detailed description of the plan should be required.
- Evaluation should be measured by selecting criteria for the area where the purpose can be achieved.
- The result of the evaluation should contribute to the plan and/or activities.

- Scope of the health problems resolved in the area.
- Trends in the accessibility of the community to the health personnel, considering that persons many other duties.
- Appropriate manpower mix to meet the health and medical care demand in the community.

- With regard to the health and medical care delivery system:

  - The function of the health care delivery system.
  - Quantitative measurement and qualitative analysis of referral cases.
  - Economic impact which can be obtained through the function of healing and the medical care delivery system.

- With regard to expenses:

  - The required investment cost.
  - The operational expenses.
  - The difference between the new and existing system per unit cost.
  - Total expenses of the new and existing system, and the economic advantages.

The above items of evaluation, (macroscopic) should be performed at a policy-making level; however, in terms of microscopic evaluation, the results should be immediately utilized in the following plans and activities.

The key health personnel in the demonstration project is the community health practitioner, and the items of evaluation for the health workers, recommended by Prof. Douglas Brown of Cornell University, are as follows:

- Quantitative productability and qualitative performance.
- Knowledge of duties.
- Expertise, understanding and initiative of given duties.
- Adapdability to new duties and tasks.
- Condition of reliability, accuracy and observation of regulations.
- Attitude towards occupation and co-workers and concentration on duties.
- Abilities of providing services to patients or to other contacting persons, courteousness, and attitude as professional experts.
- In the event that the duties require contacts with other agencies or their personnel, the capability of performing that function.

It is believed that these items of evaluation should be frequently utilized by the immediate supervisor for evaluation in the demonstration project.

Reference Items

a. Items requiring consideration in determining the evaluation are as follows:

2) What should be evaluated in the comprehensive health care demonstration project?

- The Determination of Evaluation Subjects -

The subject for evaluation should be clearly specified in the first stage of all project evaluations. The determination of the item required for evaluation should have a relation to the goals of the project, and this can be divided into the macroscopic the microscopic subjects of the evaluation. In order to determine this macroscopic item for the evaluation, the purposes of the comprehensive health demonstration project shall be outlined as follows:

- New type of health manpower - the training of new health personnel who will provide all other integrated health services, including medical care provided only by the physician in the past;
- New health personnel should be utilized within the health care delivery system, and
- The expenses should be less, as compared with that of the existing system, and can be affordable to both the Government and the general public
- This should sufficiently meet the currently unfulfilled demand of the community, especially the low-income people.
- Health care of the community population can be promoted;
- Demonstrate the project successfully (resulting from the successful demonstration of the project, entrusted to replicate this system in whole country).

Therefore, the basic (macroscopic) goals of the evaluation should center on the idea of whether or not the purpose of the project can be attained and promoted.

The items required for evaluation, which should be selected through the health demonstration project, are as follows:

- In connection with the training of the new type health workers (Community Health Practitioner):

  - Do they have sufficient abilities to solve the community's health problems?
  - Ability of the CHP's diagnosis.
  - Quality of work produced.
  - Skill, understanding and initiative in carrying out assignments and solving job-related problems.
  - Can the time involved in training be reduced?
  - The efficiency of training with consideration of professional expectancy.

- With regard to the activities of the health personnel:

  - The catchment area and the population coverage.
  - Productivity of the health personnel? Efficiency?
  - Acceptability of the community population toward the health personnel.

* Subject of the evaluation -- First of all, the subject of the evaluation should be determined. In other words, we should determine whether the subject should be projects such as the primary health care or maternity and child health; whether it should be such facilities and organizations as health centers, hospitals or training agencies; or whether it should be such services as safe water supply, sewage treatment, or provincial health services offering various programs in comprehensive fashion. As for the subjects requiring consideration in determining the items for evaluation, we should weigh whether or not those deserve evaluation in terms of scope or potential importance. It is not adequate to cover even extremely small scale activities in the evaluation items.

* The level of evaluation -- Since it is impossible evaluate the whole spectrum of the organization from top management to the lowest echelon, we should determine what subject to evaluate, to be determined by the level of the organization.

* Clarification of the evaluation purpose -- The purpose of evaluation should be specified: In clear and detailed terms, we should determine whether or not the evaluation should concern progress, efficiency or effectiveness; whether these should be brought into a single item; whether the evaluation should be purported to support the budget formation.

* Tracing factors of restriction -- The factors which restrict the potential of the evaluation or reduce the range of the evaluation should be checked in advance.

* Decision on the results of the evaluation -- The option concerning the result of the evaluation should be specified. We should determine in advance under what circumstances the project should be continued or taken over by other organizations; whether the implementation of the project should be stepped up; whether the project should be jointly implemented with other projects services; and whether the budget allocation should be reconsidered. We should leave open the possibility of considering these items based on the results of the evaluation.

* Where evaluation report should be submitted -- This item should be specified in advance.

The contents of the evaluation may be viewed differently depending on the places to which the evaluation reports are to be submitted. The evaluation report should be compiled in the best possible economic fashion while to avoid overly expensive printing and publication.

b. Information required for the evaluation

At each level the following items should be considered in order to confirm the information required for the evaluation:

- Summary of the answers to items up for the evaluation, and the period required for the evaluation.
- Record of clear definitions of the problems to be resolved through the implementation of the projects.

* The criteria for evaluating the validity and objectivity of the project from a policy deminsion.

* Table of the purposes and goals, approach selected to attain the goals, summary of resources to be utilized (such as manpower, budget and financial resources), mile-stone or check-point -- all these are necessary information required for the evaluation.

On the basis of such information, criteria for evaluating the validity of the project or project plan should be established.

* It should be established whether or not it is possible to obtain information regarding the utilization of resources, guideposts for measuring the progress of the project or its process.

* It should be confirmed whether or not the efficiency concerning the results of the project can be summarized.

* In order to measure the effects of the project we should confirm the possibility of obtaining information on problems involved in health aspects before the implementation of the project or during its early stage.

* In order to measure socio-economic impact, we should conform whether or not there was such information before the implementation of the project, during the early stages of implementation, or at the time of the evaluation.

3) How the Evaluation Should Be Done

There must be criteria and indicators for development of evaluation criteria.

The criteria and indicators are also used in formulating or implementing plans. The criteria or indicator used for the actual evaluation is the same as is used for the formulation of plans.

The indicator is a variable to measure change, while the criteria is the standard with which to compare activity.

a. Indicator

An indicator which can measure change directly or indirectly should be carefully selected and should reflect the trends in progress of project. It can also be utilized in analyzing the activity related to the project.

The indicator should meet such requirements as validity, objectivity, sensitivity, and specificity. In the indicator, there also must be availability, or, easy access to the required data.

Requirement for Indicator

Validity - items which require measurement should be done correctly.
Objectivity - result should be identical on any occasion under any circumstance.
Sensitivity - condition or phenomenon should be accurately reflected.
Specificity - change in the condition or phenonenon should be reflected in a specific activity or programme.
Availability - required data should be easily accessible.

b. Basis

A basis may be considered as something relating to social, technical or administrative elements. For example, the possibility of supplying safe water can be on a social basis, while guaranteeing the purity of the safe water by using certain technical standards can be or a technical basis. The existence of a regional society to guarantee the steady supply of such safe water can be on an administrative basis.

The primary purpose of the establishment of a basis is to induce judgement, and such judgement is sometimes done by expressing the values in number according to the given basis.

In dealing with a health project, the establishment of the basis should be done in terms of measurement.

However, it is difficult to do so with regard to the social or administrative basis.

In this light, the basis of the evaluation is not so much a measure of analysis as a means of analysis.

c. Method of evaluation item

The main theme for this seminar concerns evaluating the performance of the workers. We may enumerate the method of evaluation by each item from a macroscopic angle related to the activity of the workers.

* Ability of the workers to diagnose the society of the region

Workers are posted after being trained to perform comprehensive activity. When they are posted to the regional society and are prepared to start their activities, the workers should track down problems involved in the regional society and then determine the priority of projects in order to resolve problems before embarking upon the implementation of the project. That requires an evaluation of the worker's ability to diagnose the regional society. Population Coverage (Theoretically Accessible People) and Catchment (activity) Area.

In establishing replicate plans, workers and the population coverage of facilities should be measured. For this replication, the amounts to be offered should be indicated with regard to infant and child health control, prenatal and postnatal control, and family planning. In the case of general patients, it should be measured by such medicins as sex, age and position, and by the equitability of the project, as well as the area to which remote treatment is provided.

Population coverage can be expressed in the following simple manner:

1. Plot on the map utilized at a certain health post.

2. Tabulation on the table is as follows. It can be calculated for the utilization pattern by villages in a certain period.

Table 1.

Village	Population (target)	Service Provided w/in the period	Service Provided per 100 persons

In the demonstration project, the resultant formula below is expected.

$$\frac{S\,1}{P\,1} = \frac{S2j}{P\,2} = \frac{S\,3j}{P\,3} = \cdots\cdots \frac{Snj}{Pn} \quad \ldots \text{ Fomular 1}$$

Provided that: Pi = Population of (i) Village (Ri)
Sij = Population who receive (j) service at (i) village (Ri) or number of times

However, the service provided at a certain facility is related to the distance from the utilizer's place, and thus the above F.1 will be changed as below to F.2.

$$\frac{Sj}{P1} \quad \frac{S2j}{P2} \quad \frac{S3j}{P3} \quad \frac{S4j}{P4} \qquad \frac{Snj}{Pn} \quad \text{... Fomula 2}$$

Therefore, the real population coverage can be calculated from Fomula 1, and the out-reach service will be provided in another area of the population coverage catchment area.

Figure 1

Utilization Rate

Catchment Area Covered Area Distance

As to the catchment area, we expect it to be as wide as possible, though there may be some difference, according to the features, such as the curative agency and workers or the residents and transportation advantage. The in-patient area of the hospital is wide, and the out-patient area is narrow, and the effect in which the regional feature is affected by the catchment area should be closely examined in the demonstration project.

Figure 2 - Catchment Area of Hospital

Out-patient area in-patient area distance (to residence)

Productivity of Workers

The productivity of workers is related to the demand of the community residents, and also with their acceptability, accessibility, and credibility. If the residents' acceptability and credibility is not increased, the effective need will not be there, no matter how area accessibility is enhanced by deploying workers to the area where they are needed. Therefore, the service performance provided by the workers can be the indicator covering acceptability and credibility.

Productivity is expected to be the same for workers whose occupational category and given condition are the same, The particular productivity between workers or categories can be compared through the service performance of workers.

In case of the same category, factors showing the degree of productivity of the workers whose performance gets out of x + s should be thoroughly studied. Problems should be promptly corrected. On the other hand, in evaluating the productivity of workers, it should be divided into types of services.

Project Efficiency and Service Quantity of Workers

Efficiency represents the relationship between the contents and results of a project or activities invested with manpower, financial resources, funds, techniques, time, methods, etc. Analysis of the efficiency is aimed at promoting the implementation of the project and reviewing the results. For this demonstration project, efficiency can be measured by the simple model below, and the results can be compared to each other,

Provided that: $Eff. = \frac{R}{E}$

Eff = Efficiency

E = Effort (input)

R = Result (output)

Change of Utilization Pattern

Since a new type of health manpower has been deployed to the demonstration projects, considerable change in the health and medical care utilization pattern of the residents is expected. This model is applied to medical care activities such as maternal and child health, family planning, etc.

Referral Functions

A new type of health workers provide services at the lowest step of the health and medical delivery system, and have high reliability with regard to the residents. They have the ability to judge which diseases should be referred. In active referral services provided by them, the utilization of new workers will be increased, while the by-pass phenomenon, or superior, primary, secondary and tertiary agencies will be reduced. Therefore, the demand for the above agencies can be judged. In the measurement of referral functions, referral activities should be analyzed.

4) Who should evaluate?

The evaluation should be done by individuals, a group, or managers who are involved in all levels of operation of the project. The World Health Organization had this to say of the evaluation: "The evaluation should be done by persons who offer the services, the persons who use the services, the persons who manage the project at various steps of the health and medical delivery system and the persons who are in charge of technical coordination."

The following chart provides ease in understanding. The undertaker of the project should evaluate not only the operation plan, but the status of the project's implementation the results are then reflected in the next plans.

Reference:

Items requiring evaluation by strata --

a. Items requiring evaluation by the lowest echelon of the project undertakers

* Validity should be checked as to whether the formulation of the plan will help meet essential demands among the residents; whether it is compatible with policy and guidelines; and whether the order of priority is optimum.

  Validity should be evaluated during the after the implementation of the project.

* A clear evaluation should be made as to whether the progress is in keeping with the schedule; what goals were attained; or what should be done to offset lagging progress.

* Alternatives should be developed, and after careful review should be implemented after the evaluation is done to determine what results can be extracted from the project or activity and if the results are efficient; if the resources, know-how and time were used efficiently; if there might be another method which reaps the same results, or if there might be another more efficient method to gain the same effects with the same input.

* Measurements should be done so as to determine whether the desired effect was generated from the project; whether the problems involved regarding the health aspects were reduced; whether undesirable health situations were rectified; whether the evaluation of the effects matches the level of the predetermined goals.

  The results should be evaluated, noting that the analysis of the effects will contribute to establishing the project plan or to elevating the effects of the projects.

* Evaluation should be done as to how much the project or the activity done has contributed to the social and economic development of the regional society or to resolving whole health problems.

b. Items requiring evaluation by middle-level managers and those responsible for making decisions.

Since middle-level managers command a number of sub-ordinate posts and organizations, it is possible to make comparative evaluations of the performance and activities involved.

Various projects are controlled and coordinated by those above the middle-level managers, and there it is possible to make a comprehensive evaluation of many projects and improve the substance of the implementation.

While the involvement by those who actually undertake the project is relatively simple, those who are in charge of the evaluation have many things to consider such as pinpointing inter-relationships, and for this reason, the method of their evaluation becomes complex.

At that level, differential analysis is required. It is necessary to predict what effects of maintaining the present status will bring about in the future.

Where those who are responsible for making decisions are concerned, the evaluation items which are related to the long-term prospect carry heavy importance.

5) Opinion on the Implementation of the Comprehensive Health Demonstration Projects

It may be too early to reach to any conclusion on the outcome of the comprehensive health demonstration projects in which a new type of health worker has been utilized, because since there are still many questions to be answered.

We would like to express a partial opinion, however, on the ground that the demonstration projects have been enforced for an appreciable duration and that the Korea Health Development Institute has collected various statistical data from the health demonstration project sites. Our opinion is by no means refers to details, so for the project administrators its availability would be very limited, but for the intermediate management level or those engaged at the decision-making level, it is believed that it would be helpful for the direction and outcome of the project and for finding new ways for comparisons and examinations.

a. Productivity of Workers

The productivity of workers could be analyzed based on their effort and performance. Since the new workers in the comprehensive health demonstration projects are the community health practitioners, the number of contacts with patients for medical treatment and consultation made during their project activities represents a good indicator for the measurement of their productivity.

Based on the number of visits as the indicator, aside from other various works performed by them, the monthly performance record, per worker by Gun (county) is shown in Table 1.

Table 1

Monthly Medical Care Performance By Workers in Guns

	Hongcheon	Okgu	Gunee	Average
CHC physician	756	771	326	676
CHC trainee physician	-	130	-	130
PHU practitioner	189	193	338	218
PHP midwife	-	-	79	79

Source: KHDI quarterly survey (Second quarter, 1979)

According to the above table, the performance record of the physicians of Gunee community health center and the trainee physicians (specialists) of Okgu community health center, is poor. The performances of the practitioners of Hongcheon and Okgu community health centers are poorer than that of Gunee community health center. The good records shown by the physicians of the Hongcheon and Okgu is believed to be due to the fact that their community health centers are located in densely populated areas. The poorer record in the Gunee gun is believed to be derived from the fact that the physicians have been stationed in a small Myon with a population coverage of 10,557 persons, and that it is remotely located from the seat of the Gun (county). Which area is most appropriate for stationing the physicians? That is a subject to be studied in depth hereafter. The optimum productivity of the community health practitioners and the population coverage can also represent research subjects in the future. Compared to the improved records of other counties (Okgu and Gunee), Hongcheon Gun recorded poorer performance in the second quarter than in the first quarter of 1979. Its reason should be immediately revealed through investigation (see Table 2).

Table 2

Monthly Medical Care Performance by Practitioner

	First Quarter	Second Quarter
Hongcheon	276 visits	189 visits
Okgu	185 "	193 "
Gunee	308 "	338 "

Source: KHDI's Performance Survey, Quarterly (1979)

The workers engaged in the demonstration project are requested to do preventive care, but actually, as shown in Table 2, the preventive care activities are done less by the worker whose primary duty is medical examination and treatment, and more by those who are in a lower rank and not engaged in treatment.

It is presently difficult to expect the physicians to do preventive care. But how much of his time should be alloted to the work of supervising the workers at the lower rank and giving technical support and advice to them concerning preventive care? To what degree should the workers engaging in medical treatment share the activity of preventive care? These are the research subjects that need to be solved promptly.

The monthly number of medical treatment by medical practitioners is shown in the following table. The numbers are far less than 1,000 visits per month in the advanced countries.

Table 3

Monthly Preventive Care Performance by Gun Workers

	Hongcheon	Okgu	Gunee
CHC physician	-	-	38
CHC trainee physician	X	-	X
PHU practitioner	64	106	66
Nurse	X	X	281
Community Health Aide	245	544	293

Notes: -/No performance
X/No worker

Source: KHDI's Quarterly Survey (Second quarter, 1979)

Reference: Monthly Medical Care by Medical Practitioner

Major City	300 persons	
Minor City	430 "	..... surveyed by KMA in 1976
Rural Area	334 "	
Average	355	
Rural Area	327	.... provided by KHDI in 1977-1978

b. Operational Expenses for the Primary Health Unit

As shown in Table 4, the annual operational expenses for the Primary Health Unit in the demonstration projects, if a medical practitioner is appointed, are three times as much as that of the community health practitioner. If the performance and efficiency of the medical treatment is equivalent, it could be calculated that the cost of medical treatment by the community health practitioner is far less expensive.

As previously mentioned, although the medical treatment record by the community health practitioner is inferior to that of the medical practitioner, the part of the health center with a community health practitioner has shown the record equivalent to that with the medical practitioner. Taking into account its probable improvement in future, health centers with community health practitioners could be increased in numbers, because the center with a CHP could be operated less expensively, compared to the center with a medical physician, who is hard to secure. Thus the former would be able to provide the residents of isolated areas with more convenient geographical access to medical treatment.

Table 4

Annual Budget (operational expenses) by Type of Health Center

	Community Health Center		Primary Health Unit	
	(Budget)	(%)	(Budget)	(%)
Personal Expenditure	11,525,800	67.5	2,496,000	48.6
Night-Duty Allowance	301,700	1.8	301,700	5.9
Traveling Expenses	384,000	2.3	96,000	1.8
Reception Expenses	213,000	1.2	85,400	1.7
Expenses for Books	50,000	0.3	20,000	0.4
Commision Fees	50,000	0.3	20,000	0.4
Public Expenses	290,400	1.6	290,400	5.6
Fuel Expenses	338,200	2.0	182,600	3.6
Maitenance for Equipment	200,000	1.2	100,000	1.9
Medical Fee	2,160,000	12.7	1,080,000	21.0
Reserve Fund	1,551,310	9.1	468,110	9.1
Total	17,064,410	100.0	5,140,210	100.0

Source: Special Budget, Community Health Project, Okgu Gun, 1979

* Personal Expenditure for existing workers is not included.

Efficiency of Workers

Given the operational efficiency of the community health center and the primary health unit as $\frac{Pij}{Ocij} = 1$, the operational efficiency of each

Gun's primary health unit is as shown in Table 5. In the case of the community health center, the Okgu County registered highest, and in the case of the primary health unit, Gunee County was highest. Operational efficiency is calculated without the computation of preventive care records because the study on the time-motion of the health workers is not complete. The calculation also did not consider the area and social characteristics. In the future, the method of evaluating the operational efficiency of each community health center with the consideration of such characteristics should be developed.

Table 5

Efficiency by Model Gun and Community Health Center

	Hongcheon	Okgu	Gunee
Community Heath Center	1.12	1.14	0.48
Primary Health Unit	0.87	0.89	1.55

Notes: Calculated from KHDI's Quarterly Performance Survey (Second quarter, 1979)

C. Catchment Area and Population Coverage in the Area

For the demonstration projects, it is of major concern to define the distance from the community health center or the primary health unit where it can exert its influence with its facilities, as well as the population living in the catchment area.

Generally speaking, inhabitants in the mountainous areas tend to utilize the medical facilities within their areas, since transportation is less developed, but those who live in open fields characteistically utilize various medical facilities. According to the KHDI's survey conducted on the number of case histories in Okgu County, as shown in Table 6, the utilization of the primary health unit by the inhabitants from farther away than three kilometers sharply decreased, but the community health center was utilized by a considerably large number of people who live in villages located beyond the three kilometer radius.

Table 6

Outpatient Rate by Distance

	Less than 1 Km	1-2.9 Km	More than 3 Km
Community Health Center	21%	10%	10%
Primary Health Unit	27%	13%	4%

Provided that: $\frac{\text{Out-patient required more treatment}}{\text{population within the distance}} \times 100$

Although further study in detail of the medical treatment sphere of each community health center should be made, the theoretical number of population to be covered by each primary health unit by Gun (county) could be calculated as in Table 7, using the three kilomer radius of areal coverage.

Table 7

Theoretical Population Within Catchment Area

Hongcheon		1,837 persons
Okgu		9,806 persons
Gunee		2,939 persons
Provided that "d"	Hongcheon	65 Km^2
	Okgu	347 Km^2
	Gunee	104 Km^2

In the table above, "d" equals the average of the Gun (county). The real figure should be less than the average. The study on the propensity of inhabitants in both mountainous and open field areas in the utilization of medical facilities, as well as the development of policy and measures which take into consideration the results of the study, are subjects for the future. On the other hand, the method of evaluating the worker's productivity while taking into account the factor of population density, also should be studied in future.

d. Utilization Pattern

The difference in the pattern of utilizing the health and medical facilities are generally caused by the following factors:

* Factors relating to the visitors:
  (1) Intelligence and educational level of the utilizer
  (2) The existance of medical facilities and manpower, as well as knowledge of the means of utilization, and
  (3) The ability of utilization including transportation, financial capability, time, etc.

* Factors relating to the service providers:
  (1) Accurate understanding of the health and medical treatment problems of the people.
  (2) Capability of providing services needed, as well as the attitude and intention of service providers.

Assuming that the various education and training of the workers and their quality and ability have been generally equalized, various patterns of utilization could be shown as follows:

(1) Sex Rate of PHU Utilizers

The sex of the utilizers of the primary health unit in the KHDI's demonstration areas is shown in Table 8 below.

The Utilizers under the age of fourteen, both male and female are large in number. However, excepting Okgu Gun, more female utilizers above the age of fifteen are shown in this table.

Table 8

Sex of PHU Utilizers by Age and Rank

	-14	15-59	60+
Hongcheon	123	81	99
Okgu	148	102	106
Gunee	135	79	69

Source: Survey by Quarter(third quarter, 1979)

When compared to the first class medical insurance, as shown in Table 9, the insurance has also been utilized by more men in the age group under fourteen, and by more women in the age group over fifteen.

Table 9

Sex of Medical C re Utiiizers (first class enrollees)

	-14	15-64	65+
Insurance Enrollees	129	74	78

Source: Federation of Medical Insurance Societies, comprehensive bibliography on medical insurance statistics, 1977

The cause for fewer female utilizers under the age of fourteen and that of more male utilizers in the Okgu Gun area are subjects to be separately studied.

(2) Age Distribution of Utilizers at Primary Health Unit

Structure rate of utilizers in the age bracket of fourteen and below is small, and that of the utilizers in the ages between 15-59 is large, as shown in Table 10. The difference in utilization should be studied in future.

Table 10

Age Distribution (structure rate) of PHU Utilizers

Hongcheon	26.4	63.3	10.3	100.0
Okgu	40.7	49.6	9.7	100.0
Gunee	25.0	47.7	17.3	100.0

Source: Quarterly Survey (3rd quarter, 1978)

(3) Primary Health Unit Utilizers' Disease Pattern

According to the Federation of the National Medical Insurance society's survey, there is a difference between the disease pattern of those utilizing the medical facilities under the demonstration project and those who depend upon the general medical organizations as shown in Table 11.

The utilizers under the demonstration project had relatively few respiratory and digestive diseases, but many infectious and parastic diseases in addition to toxicosis, accidents, and so on. Study, by disease, is required to determine different causes, and to make efforts toward improving the quality of the health worker's performance.

Table 11

Medical Insurance and Structure Rate of Medical Facility Utilizers in Demonstration Project Areas

	Medical Insurance	Demonst. Area
Diseases of the Respiratory System	31.3	16.2
Disease of the Digestive System	23.1	13.0
Disease of the Skin & Subcutaneous Tissue	10.7	11.8
Disease of the Nervous System & Sense Organs	9.8	8.9
Infective and Parasitic Diseases	5.6	11.4
Accidents and Poisonings	4.5	7.3
Diseases of the Genito-Urinary System	4.0	5.5
Diseases of the Circulatory System	3.3	1.1
Diseases of the Musculoskeletal System & Connective Tissue	2.4	2.6
Symptoms & Ill-Defined Conditions	1.5	19.2
Mental Disorders	0.9	0.1
Endocrine, Nutritional & Metabolic Diseases	-	0.9
Neoplasms	-	0.6
Complications of Pregnancy, Childbirth & Puerperium	-	0.5
Others	2.9	0.9
Total	100.0	100.0

Source: KHDI Quarterly Survey Federation of Medical Insurance Societies, Comprehensive Bibliography on Medical Insurance Statistics, 1977

e. Transfer System

In order to efficiently utilize the health and medical care delivery system, its establishment and function is important. The number of patients transfered from the lower rank to the higher determines the manpower needs and facilities for the latter.

The transfer system originally established in this demonstration project has been unsatisfactory in carrying out its function, because it has failed to obtain the cooperation of some civilian medical facilities. Although the investigation on these by-pass has not been completed, the rate of transfer by Gun and by type of worker is as shown in Table 12.

Table 12

Transfer Rate by Gun and Worker

	Physician	Practitioner	CH Nurse
Hongcheon	3%	4%	-
Okgu	0.9%	3%	-
Gunee	1.1%	3%	4%

Source: Quarterly Survey, KHDI (Second quarter, 1979)

In thetable, the rate of transfering patients beyond the capacity of the workers registers only 3-4%, indicating that a considerably large part of the medical demand in the community could be met by the health workers rather than physicians. In respect to the by-pass phenomenon, its frequency of occurrence and characteristics should be studied.

Summary of Opinion

The comprehensive health demonstration project, utilizing a new type of health workers, has not yet reached the stage of drawing conclusion on its outcome. The opinion presently obtained is summarized as follows:

-- The new type of health worker, that is, health care worker, has been received and utilized by rural inhabitants, indicating sufficient proof that the productivity of the community health practitioner has been increasingly promoted.

-- In contrast to the physicians, the community health practitioners have endured their work in the rural areas. The primary health unit where the community health practitioners work can be operated with one-third of the cost of the health center where physicians work.

-- The working radius of the community health practitioner is estimated to be about three kilometers. The range of the radius depends upon the areal chracteristics. This should be studied in the future.

-- Although it is a subject to be further studied, it is assumed that the community health practitioners are able to successfully treat 95% of the rural medical demands.

6) Conclusion

For every project, the evaluation of its achievements and outcome are absolutely necessary. There is, however, no publication which systematically reported the outcome of the project, or no evaluation model developed by project. Under these circumstances, it is not easy to prepare the evaluation of a project. Because of this situation, we believe this report prepared for the study group is not sufficient.

Evaluation means a developed way of thinking and an exploration for better methods and means for development. The combined efforts and cooperation from all participating groups could produce a near perfect model.

In this respect, we believe that this report should be increasingly refined, added to, complemented and revised with the support and advice from all those concerned with the project.

* * * * * * * * * * *

APPENDIX : What type of health indicator is observed in the advanced countries (for instance, in America)?

1. Health (the sanitary condition of the people)

1) Population

a. the movement of population
b. indicator for dependents
c. population estimates & index of change by year
d. composition of population (by sex and age)
e. estimation of population composition (by sex and age)

2) Productive Capacity

a. production rate by age and stratum
b. numbers of productive adults and existing children
c. ages of primiparae
d. interrupted pregnancies (by birth versus feature)
e. bad effect rate of contraception (by method)

3) Mortality

a. mortality rate (by sex and age)
b. death rate for correction
c. death during parturition
d. mortality by causes (heart disease, cancer etc.)

4) Factors in Determining Health

a. number of prenatal control months and birth
b. " " (by age and stratum)
c. immunity (preventive vaccination) condition of the age group of between one and four years
d. propensity to consume food by sex, age and stratum
e. dietary methods by sex, age and stratum
f. self-evaluation on exercise and activity ability
g. trauma condition by age, stratum and place

5) Health Measurement

a. self-evaluation of health condition
b. chronic diseases causing limited activities
c. frequency of occurance of acute conditions
d. activity limit and disease duration
e. demand for dental care
f. frequency in disease occurance reports
g. premature births

2. Utilization of Health and Medical Resources

1) Utilization by out-patients

a. physician visits by place
b. disease pattern of patients
c. treatment contents, by disease
d. initial location of patients with external injuries
e. type of medical care providers

2) Short-term Hospitalization

a. number of inpatients (hospitalization days, etc.)
b. " " (by disease)
c. number of examinations and operations, by type, at hospitals

3) Long-term Facilities

a. accomodation conditions

3. Health Resources

1) Manpower

a. employment conditions
b. active medical manpower
c. number of trainees at health training institute

2) Facilities

a. number of facilities and scale by type
b. manpower rate compared to patient number

4. Expenses and Investment

1) Expenses Provided to Public Agencies

a. general production of population
b. by resources
c. services by type

2) Medical Expenses by Age

a. by service type
b. by financial resources
c. by financial institutions

3) Change of Medical Expenses

   a. consumption index
   b. by service type

4) Hospital Expenses

   a. expenses by day
   b. consumption expense index
   c. hourly rate of hospital workers, by type

5) Expenses for institutions for the aged

6) Physician income and medical fee by visit

7) Medical expenses for cancer treatment

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Table 1. Purpose and General Methods of Program Evaluation

	Experimental Study	Quasi-Experimental Study	Correlational Status Study	Survey	Personnel or Client Assessment	Systematic "Expert" Judgements	Clinical or Case Study	Informal Observation or Testimony
x - Likely investigation method								
I. To contribute to decisions about program installation								
A. Need								
1. Frequency								
a. Individual				x	x	x		
b. Society				x		x		x
c. Other (that is, industrial, professional, governmental)				x	x	x		x
2. Intensity								
a. Individual				x	x	x		x
b. Society				x		x	x	x
B. Program conception								
1. Appropriateness						x		
2. Quality						x		
3. Priority in the face of competing needx						x		
C. Estimated cost								
1. Absolute cost				x			x	
2. Cost in relation to alternative strategies oriented toward same need				x			x	

	Experimental Study	Quasi-Experimental Study	Correlational Status Study	Survey	Personnel or Client Assessment	Systematic "Expert" Judgements	Clinical or Case Study	Informal Observation or Testimony
B. Program content								
1. Relevance to program objectives						x		
2. Coverage of objectives						x		
3. Technical accuracy						x		
4. Degree of structure						x		
5. Relevance to backgrounds of clients						x		
6. Effectiveness of components	x	x		x		x		
7. Sequence of components	x	x						
8. Popular acceptance				x				x
9. Professional acceptance	x	x		x		x		x
10. Client acceptance				x		x		
11. Staff acceptance				x		x		
C. Program methodology								
1. Degree of client autonomy						x		
2. Effectiveness of delivery methods	x	x				x		
3. Pacing and length	x	x				x		
4. Reinforcement system, if any	x	x				x		
5. Client acceptance								x
6. Staff acceptance								x

	Experimental Study	Quasi-Experimental Study	Correlational Status Study	Survey	Personnel or Client Assessment	Systematic "Expert" Judgements	Clinical or Case Study	Informal Observation or Testimony
D. Program context								
1. Administrative structure, auspices						x		x
2. Program administration procedures						x		x
3. Staff roles and relationships				x		x		x
4. Public relations efforts				x		x	x	x
5. Physical facilities and plant						x		x
6. Fiscal sources and stability						x		x
7. Fiscal administration procedures						x		x
E. Personnel policies and practices								
1. Clients								
a. Recruitment					x			
b. Selection and placement, if any	x	x	x		x	x		
c. Evaluation, if any			x	x			x	
d. Discipline, if any			x	x			x	
e. Retention			x	x			x	
2. Staff								
a. Selection and placement		x	x		x			
b. In-service training		x	x			x		
c. Evaluation for promotion, guidance, retention, and so on		x	x	x		x		

	Experimental Study	Quasi-Experimental Study	Correlational Status Study	Survey	Personnel or Client Assessment	Systematic "Expert" Judgements	Clinical or Case Study	Informal Observation or Testimony
3. Administrators								
a. Selection			x		x	x		
b. Evaluation for promotion, guidance, retention, and so on			x	x	x		x	
IV. To obtain evidence favoring program to rally support								
A. Popular	x	x		x	x	x		x
B. Political and financial	x	x		x	x	x		
C. Professional	x	x				x		
V. To obtain evidence against program to rally opposition								
A. Popular	x	x		x	x	x		x
B. Political and financial	x	x		x	x	x		
C. Professional	x	x				x		
VI. To contribute to the understanding of basic processes								
A. Educational	x	x	x					
B. Psychological	x	x	x				x	
C. Physiological	x	x	x				x	
D. Social	x	x	x				x	
E. Economic	x	x	x					
F. Evaluation (methodology)	x	x	x	x	x	x	x	x

Table 2. Examples of Types and Sources of Evidence Frequently Associated with the Various General Methods of Investigation

x - Likely source of evidence	Test Scores[b]	Questionnaire or Interview Data[c]	Logs, Diaries[d]	Observations[e]	Ratings[f]	Clinical Examinations[g]	Records[h]	Social Indicators[i]	Expert Opinion	Hearsay, Chance Encounters
I. Experimental study										
A. Differences between performance of clients in the program and performance of nonclients	x			x	x	x				
B. Performance differences for clients exposed to program variations	x			x	x	x				
C. Data on differential program effects for clients with different characteristics	x	x		x	x	x				
II. Quasi-experimental study										
A. Changes in client performance over the time of exposure to the program	x			x	x	x				
B. Changes in client performance for different program components, variations	x			x	x	x				
C. Differential predictions of "success' for clients exposed and not exposed to theprogram	x				x		x			

	Test Scores[b]	Questionnaire or Interview Data[c]	Logs, Diaries[d]	Observations[e]	Ratings[f]	Clinical Examinations[g]	Records[h]	Special Indicators[i]	Expert Opinion	Hearsay, Chance Encounters
III. Correlational status study										
A. Correlations between program characteristics (sometimes including costs) and client performance	x	x		x	x		x			
B. Correlations between client characteristics (such as race, sex) and their performance	x	x			x		x			
C. Correlations among program characteristics		x	x	x			x			
D. Correlations among client measures	x	x			x	x				
IV. Survey										
A. Projections of manpower needs		x					x	x	x	
B. Summaries of attitudes and opinions about an ongoing program among program-delivery staff		x								
C. Descriptions of program characteristics, operations, costs		x	x	x			x			
V. Personnel or client assessment										
A. Profiles of characteristics of entering, leaving, past or prospective clients	x	x			x	x	x			
B. Summary descriptions of characteristics of program personnel	x	x			x		x			

VI. Systematic "expert" judgment								
A. Recommendations by a commission appointed to delineate a problem and recommend possible solutions								
B. Report of program processes/materials review or evaluation panel								
VII. Clinical or case study								
A. Analysis of program processes (implementation, management, evolution, and so on)								
B. Phenomenological analysis of institutional change								
C. Summary of impressions gained from examination of special clinet or personnel groups (for example, referrals)								
VIII. Informal observation or testimony								
A. Anecdotes about experiences of particular clients, staff members, and so on								
								Test Scores[b]
x								Questionnaire or Interview Data[c]
	x	x						Logs, Diaries[d]
	x	x						Observations[e]
			x					Ratings[f]
x								Clinical Examinations[g]
		x		x	x			Records[h]
					x			Special Indicators[i]
x		x	x		x			Expert Opinion
							x	Hearsay, Chance Encounters

D. Expectations from the Activities of New Health Workers

Cho, Jae Yun
Chief, Health Division
Gyong Sang North Province

In 1978, 40% of the total population in Gyong Sang Buk Province lived in cities, and the remaining 60% in rural areas. At the same time, 80% of the medical doctors in the province worked in the urban areas, and 20% in rural communities. The number of the Province population covered by a doctor stands at 2,157 persons in the urban areas and 13,179 persons in the rural areas, thus showing a great disparity in the distribution of medical doctors between urban and rural areas.

Of 247 doctors located in the rural areas, the number of those working at the Myon level or below (excluding those working at the seats of Gun offices) amounts only to seventy persons, or 28% of the total. These seventy doctors cover 32.8% of the 218 Myons in the Province, thus leaving the remaining Myons equaling 67.8%, as doctorless villages. (The number of Myons where apprentice doctors are dispatched are counted as doctorless villages, and equal 22% of the area.)

In the age composition of seventy physicians operating at the Myon level, the age group of 50 or above is 85% and that of age 60 or above 62%, thus showing the relatively older age composition. In their qualification, "the limited area doctors" stand at 31%; physicians passed qualification examinations at 52%; and the graduates of the formal medical colleges at 17%. In their motives for working at Myon level, compulsory assignment accounted for 54%, and birth place or other relationships accounted for 29%.

With regard to nurses, the 1977 nation-wide statistics indicate that the employment rate stands at 68.5%, thus leaving the nurses equal to 31.5% unemployed. As of January 1979, 16% of the total number of nurses in the Province were unemployed.

Summarized below are the problems existing in the medicaid services in the Provinces:

1. Overcongestion of physicians in urban areas;
2. Concentration of medical facilities in urban areas;
3. Low quality of health care services provided in rural areas;
4. Current health care services stressing the curative aspect only;
5. Inadequacy in setting up a comprehensive community health program; and
6. Lack of measures to utilize surplus nurses;
7. Insufficient perception of the need for primary health care.

In view of the problems indicated above, the attainment of the goal to solve the problem of doctorless villages is hardly expectable unless a decisive policy measure is undertaken on the part of the government. The assignment of medical doctors to every rural village and remote area is next to impossible if the qualified new health workers are not developed and produced in large numbers.

Accordingly, the nurses who have already received fundamental education on health care are considered the potential medical manpower most suitable for the purpose. It is highly desirable that the training program on basic treatment be intensified including preventive health for the nurses. They then should be assigned to doctorless villages to carry out the comprehensive primary health care services in the locality.

The medical protection program initiated by the government in 1977 resulted in positive support from the people. However, the program was not fully effective due primarily to the distant location of medicaid institutions; however, the system itself was good. In reality it was frequently observed that the patients bought needed medicine at a pharmacy or a herbalist's drug store in the neighborhood, simply because they didn't want to bother traveling a long distance (16 km for an example) or waiting for two to three hours for simple treatment or a dose of medicine. These problems, however, do not exist in Gunee Gun, which is one of the KHDI health demonstration project sites. In Gunee Gun, villagers are able to obtain the needed services from the Primary Health Units located at an easily accessible distance. This closeness in distance not only contributes to the betterment of community health, but increases the efficiency of the health service project. As a result, villagers have a growing confidence in the administrative agencies, and remain grateful for the benefits they receive. Therefore, the cooperative endeavour between residents and Gun health authorities has become ever hardened, and the active involvement by residents in the primary health care has become more positive.

It is quite remarkable to see that new health workers not only play a role as leaders in solving the health and medicaid services and community health problems, but perform the activities in all aspects of a comprehensive primary health care service including health education, environmental sanitation, maternal and child health, family planning, tuberculosis prevention, as well as the curative aspects of the people.

It is now recognized throughout the world that health is a basic human right. As long as people are entitled to a healthy and decent life, the equal distribution of medicaid services must by all means be achieved. The development of medical manpower which is devoted to preventive programs and community development is also a pressing task to attain.

A new system designed fully to utilize the presently available medical forces like community health practitioner will certainly contribute greatly to the improvement of community health.

Needless to say, "Healthy minds come from healthy bodies." All of us, Gun officials and villagers alike, must exert our combined efforts through close cooperation to build a healthy and pleasant society for us and for our next generations.

E. Effect of Primary Health Care Program (Recipient's point of view)

Shim, Sung-Taek
Chief, Okgu Gun

It has been only three months since I came to Okgu Gun from my former post, Namwon Gun which is the birth place of "Choon-Hyang." Adjoining Kunsan City which is one of the harbor cities along the west-coast, Okgu-Gun is a rural country which enjoys a relatively high living standard, and has a population of 113,000, or some 21,000 households. Its 16,500 jong-bo farm land is well arranged and very fertile. Encompassing some 68 coastal islands, including Gokunsan Islands which form some of the most beautiful scenery along the west coast, Okgu-Gun has some 2,000 households or 7,600 persons engaging in fishing, the annual income from fishing contributes a considerable share to the total income of Okgu Gun.

Some eight years have lapsed, since the torch of the Saemaul Movement was lit under the banner of "diligence, self-help and cooperation." Contrary to the expectation of those who were skeptical and dubious about the Movement, rapid transformation and progress took place in every part of the country beyond our imagination; in cities, rural areas, remote mountaineous areas and isolated islands. Undoubtedly, our concerted and persistent endeavour and devotion brought about the marked improvement in environmental sanitation, mode of life and modernized thinking.

And yet, the area of health programs has been at a stalemate, without breaking away from the conventional administration characterized by its rigid formality and superficiality.

Inspired by Dr. Lee Yong-Choong, a Korean "Schweitzer," who long ago established the Rural Sanitation Research Institute is Okgu Gun under the banner of "better community health," Okgu-Gun carried out the Maul-Geon-Gang-Saup (Village Health Program) for about two years. As a result, five Health Sub-centers, each covering two Myons, and six Primary Health Posts came into existence. Because of easy accessibility to these health care posts which are located in the center of each Myon or village, mostly within ten minutes' walking distance from home, the villagers, though skeptical first, gradually began to utilize these facilities more frequently. This easy accessibility with resultant frequent dialogues also prompted the fast pace of narrowing down the gaps of spiritual culture among villagers.

Distance to Health Care Institutions

Area	Before	After
Daeya Health Subcenter	Iri 13 km Kunsan 10 km	3 km or less
Daekwang Health Post	Iri 10 km Kunsan 13 km	1 km or less
Hajeon Health Post	Iri 7 km Kunsan 13 km	2 km or less
Impa Health Subcenter	Iri 12 km Kunsan 15 km	3 km or less
Suhhae Health Post	Iri 8 km	2 km or less
Seongsan Health Post	Kunsan 5 km	2 km or less
Napo Health Subcenter	Kunsan 10 km	3 km or less
Hoihyon Health Subcenter	Kunsan 9 km	3 km or less
Yoro Health Post	Kunsan 4 km	1 km or less
Woopo Health Post	Kunsan 16 km	2 km or less

Recognizing such apparent benefits and effects, villages now began to demand that a primary health post be established in their own community. A certain village, for instance, constructed a new two-story village hall, and then requested the Gun authorities to deploy a Community Health Practitioner to their village.

A rural population who has previously been destined to live in poverty and with the pain of disease, now show a growing interest in the betterment of their health and environmental sanitation. This means that a gradual transformation takes place in their life mode and awareness structure. The village health program initiated at this juncture is considered to be a very timely undertaking, responding to the needs of villagers.

In 1976, the year before the Health Center began to provide medicaid services, the number of patients treated amounted to 570 per year, and that of those receiving health counseling to 187 persons. In

1977 the first year of medicaid services, however, the figures soared to 2,117 and 400, respectively. After the village health program started, the Daeya Myon Health Subcenter alone treated 13,032 patients and provided health counseling services to 896 persons. The number of patients treated in 1979 through this date has already surpassed 8,000 persons. By the end of the year, the number is expected to stand at some 15,000 persons. This is a 15% increase in the utilization rate over that of the preceeding year. A similar situation is observed in the Primary Health Care Post, which treats an average of 20 patients a day, and provides some 3,000 cases of health counceling per year. We are very satisfied with the sharp increase in the utilization rate, because Health Subcenters and Health Posts are now accepted by villagers as close and indispensible to their lives.

On the other hand, before the health demonstration project implementation, we attended to only the indirect deliveries, which amounted to 421 cases in 1977. However, the number of direct deliveries attended to for two months after the health demonstration project started in November, 1978, stood at eight cases, and 49 cases as of the end of July 1979. The number of indirect deliveries attended to was 614 cases in 1978, and 570 cases in 1979.

Health workers are deployed on a Myon unit basis to carry out the multi-purpose activities. We increased the number of home-visitations by health workers, which we consider to be a very essential factor in opening dialogues with villagers. The monthly home-visitations now average some 230 cases. The increased home-visitations proved to be very effective, and are highly desirable in stimulating the villager's awareness and understanding of the health program.

The CHP assigned to the Health Subcenter is now widely respected and admired, not only as the health worker but as a leading figure of their community. With the confidence earned through hard work and with unmovable personal status built up within the community, the CHP is now requested to attend the community organization meetings with all other representatives. It has become apparent that the CHP plays a vital role in all aspects of community activities such as Mother Club's activities, environmental sanitation, savings campaigns, etc. The CHP activities must be integrated into the Saemaul Movement. To attain this goal a measure is being explored to make all the community development-related activities channeled through the Health Post which will act as a focal point in this regard. These activities include the Mother Club's five major campaigns (such as one bankbook per household, nature preservation, two children per family, scientific home life management and devoted loyalty and filial piety as part of our life); establishment of a nutrition improvement center, children's nursery, children's playground, improved latrines, a village saving society, etc.

As part of the Saemaul project, a sum of ₩1,500,000 was provided to each village where the Primary Health Post is established in support of construction of a new two-story Health Post building, in order to widen the avenue to the goal which the village health program strives to attain, and at the same time to institutionalize permanent community development activities.

However, we still have problems. Not everything has worked out perfectly in Okgu-Gun. Although I anticipated no problem in achieving our goal in the six areas where the Primary Health Posts function satisfactorily, we have had to deal with the frustrations and discontent of the villagers who are left beyond the reach of these community health services. They are the residents living in the areas remotely located from the Health Posts, in the areas where Health Posts are non-existent, or in one of the nineteen isolated islands. Unfortunately, we don't have sufficient resources to satisfy them in the immediate future.

The existing Health Subcenters and Primary Health Posts are capable of benefiting only the 48,000 people within Okgu-Gun. Therefore, theoretically, we need ten additional Primary Health Care Posts to meet the need of these isolated people.

It is judged that, if the central government could lift the present ceiling of CHP's T.O. and send us ten additional trained CHP's, the entire population would be brought within the reach of health care services. If this is realized, it will enable us to render low-cost, good quality primary health care to all the population, to maximize the preventive and promotive services, and eventually to bring about a pleasant society free from the fear of disease. This will also help us in effectively carrying out the nutrition improvement program, MCH program, as well as the development of the living environment and culture of the villagers. I firmly believe that the development of the health program must be preceded by the enhancement of the people's cultural standard through which the people's awareness of health can be increased. If people's perception with respect to health is increased, then the characteristic of the health program will be changed from that of looking for recipients, to that of being sought out by them.

Another problem area I would like to present is the quality and skill of the health workers. This problem becomes more serious as the living standard and the level of knowledge of the villagers become higher. They now demand a person with more knowledge and intelligence. They want to have more dialogues. I think that the more intensified training program for the existing aide-level health workers or replacement with nurses, if possible, would be an optimal way to respond to the growing demand of residents.

The people of Okgu-Gun consider the primary health care program to be the most desirable undertaking. They want the program to continue on a permanent basis. Therefore, all of us, residents and Gun officials

alike, are fully determined to keep this program going without stumbling over any difficulties.

Never shall we be hasty in getting to our goal, nor shall we demand anything at this time. Instead, we will continue to move slowly and steadily toward the ultimate goal.

In the past, the utilization rate of the medicaid facilities was extremely low. Villagers used to regard the Community Health Center as the place where they administer vaccinations, take chest X-rays, and issue health certificates. However, the outstanding role played by the Health Center in the areas of primary health care services completely transformed the residents' negative attitude to a positive one.

Presently, each village leader, after the completion of a two-story Village-Hall building, is requesting the Gun authorities to assign a health worker, like a CHP to their village. Furthermore, a certain village leader demands that their village be designated as a health demonstration village, which the Gun office so designates under a special health promotion program unique to Okgu-Gun.

To the extent possible, we encourage them to cut down the burden of medicaid expenses to be borne by the residents by increasing the utilization rate of our health facilities. As a step to attain this goal, the Gun Office took over the existing Okgu-Gun Blue-Cross Medical Insurance Association program in July, 1979, and established a new insurance association under the initiative of the Gun Office, in order to put into effect the Class 2 Medicaid Insurance system for the population of Daeya Myon as its initial target population. All the Gun officials were mobilized to conduct an actual survey of each household and now the applications for the insurance system are being received.

When the Insurance Association is put into the cycle of normal operation, all the medicaid facilities in the villages will be designated as primary health care institutions, and the patients of general category will be changed into the status of medicaid insurance recipients. Then they will be able to receive the needed medical services at the cost of ₩600, which is only one-fifth of the medical expenses charged at the hospitals in cities. If this program ever becomes successful, this will be a revolutionary event unprecedented in the history of the health and medical insurance program.

We have several plans under contemplation to further the scope of our health service program in Okgu-Gun. They include the establishment of an MCH center, the construction of health workers' living quarters, and the purchase of an ambulance to offer 24-hour mobile services for transporting emergency patients. These are based on the recommendations made by villagers at the regular Ban-Sang Hoi (Neighborhood Association meeting).

We can visualize this country's march toward a welfare society. We, the residents of Okgu-Gun, are fully prepared and will continue to exert our best efforts in moving ahead in building a welfare society -- a welfare society in which the primary health program is flourishing, people can engage in their daily business without worries, and people are set free from the fear of disease.

Health is an important asset. When we lose our health, power, honor and other materialistic property will also be lost.

In order to accurately identify what the villagers want and think, we make visits to each village without advance notice. Through dialogue with them, we find out what they really want from us, and we check the performance of the health workers. Now and then, village leaders are invited to my office in order to exchange views on the health program and to determine a future course of action.

Lastly, we are firmly determined that we are not going to leave behind any unfinished work for our next generations or descendents to complete. It would be appreciated if KHDI, as before, continues to provide us with valuable advice and assistance in meeting our goal. We, the Gun officials, commit ourselves to faithfully carrying out the assigned duties and responsibilities in making the village health program in Okgu-Gun the most successful and exemplary one in the world.

Thank you.

Shin, Sung-Taek
Chief, Okgu Gun

F. "Comparative observation of existing public health service and Maul-Geon-Gang Saup" in Gunee County

Dr. Koo-Woong Han
Director of the Gunee Health Center

Highlights of his speech through the printed paper can be summarized as following :

- It has to be pointed out that unlike previous public health services, the new Maul-Geon-Gang-Saup, or Community Health Service, has definitely extended the scope of services down to the village level through establishment of primary health units and posts with Myon-level primary health sub-posts in our county.

It is also worthwhile to mention here that the inducement of Maul-Geon-Gang Saup into our rural county has greatly contributed in the manner by which participation of residents and family in the villages, as well as Myon the locality, have increased in the recent years.

One can also note the rather unexpected result of firmly establishing the need for a medicare delivery system, as well as that of the invaluable role of a specialist doctor among the rural health consumers in this rural county for the last three years.

The implementation of the program has clearly led the consumers to increase their use of the public sector health service voluntarily in such fields as family planning, T.B. control and MCH service.

- It may be necessary also to point out that five CHP's in Gunee Gun have served more than 4,300 persons during the period from July, 78 to June, 79, as can be noted from the attached table. Thus the monthly average of persons or residents receiving curative-services amounted to 360 persons in 1978-1979. Also, services of pre-natal and delivery cases, as well as registration and vaccination given to babies, have also greatly increased.

- There are a number of problems and difficulties being faced within the course of carrying out the primary health care service. The three main factors are shown below:

a. Lack of service facilities and equipment.
b. Lack of a sound referral system between the primary and secondary delivery service
c. Need to improve skills of CHP's and other personnel in dealing with patients.

- Regarding the MCH service and the family planning services, as can be noted from Tables 2 & 4, about 70% of the services have been increased during 1979, including that of pre-natal and post-natal care for mothers, although there are a number of problems still in existence; persistence of a boy-preference attitude, lack of family planning motivation and lack of education of mothers about family planning, although some improvements have been achieved as can be noted from Table 2 and 3 below:

So far, on the basis of my experiences, I would like to make the following recommendations for improving the primary health care system in the demonstration area:

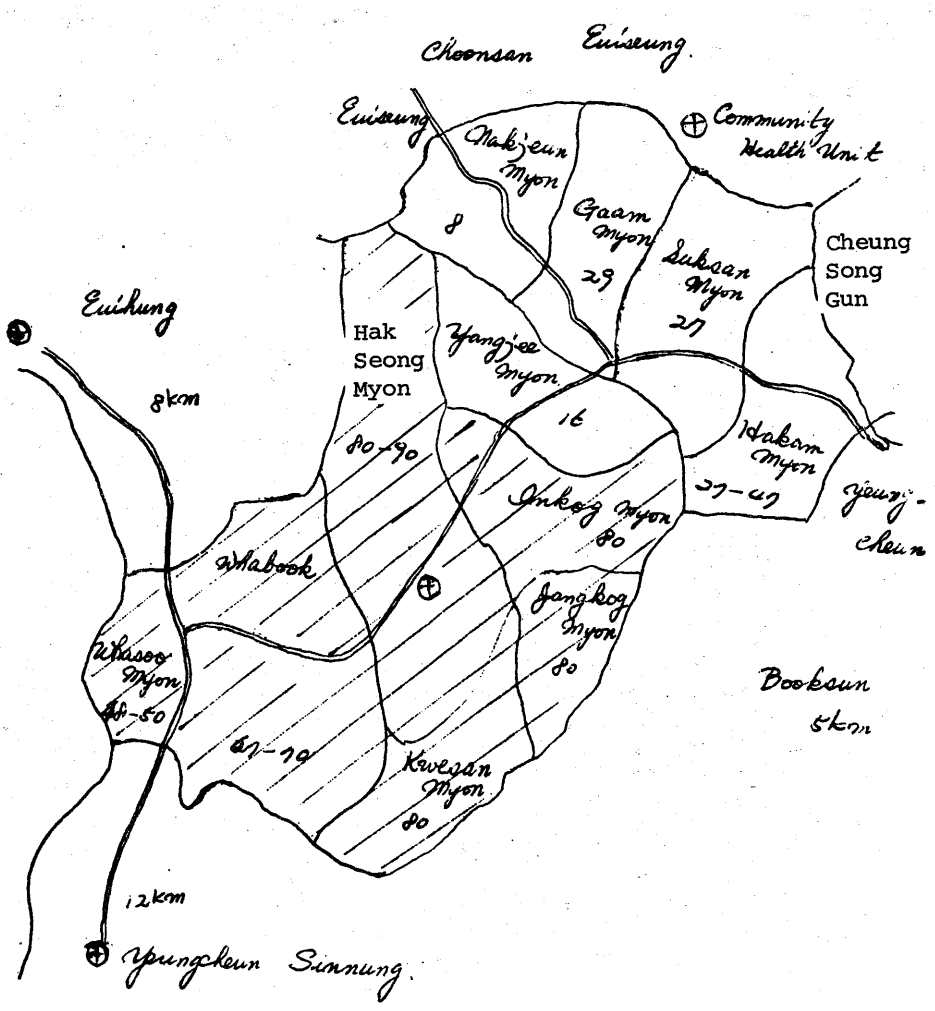
a. Primary health care system should be expanded or replicated to a larger scope, including health and sanitary education as well as the enlistment of Community participation to be strengthened through the use of new health workers, such as CHP's and VHA's.

b. In order to improve various new health workers' skills of service, in-service training should be given more often with the use of better instruction media for health workers.

c. A stronger referral system should be established between the Primary Health Unit (PHU) level and the upper level of the delivery system.

d. The future out-look of the Community Health Service or PHC can be brighter if service quality and facilities of health units can be improved and the education of the people can also be improved.

Table: Indicating comparative ratio of health service rendered in the area between Community Health Unit set up and the area without service



Legend: Figures in each Myon boundary indicate Health Center Utility ratio by percentage

1. Table of health service rendered for residents in the county by length of time and by field of service

A. Breakdown of the number of patients served

a) Total number served between July 78-June 1979: 4,269
b) Monthly average of patients served: 356
c) Monthly average of days served: 20 days
d) Daily average of patients served: 18 persons
e) Average time spent per patient: 15 minutes
f) Average time served for curative or consultation service per day: 4 hours, 30 minutes

B. Breakdown of patient referral to secondary or specialist hospital during the year

a) Internal medicine: 63 persons
b) OB & GYN (Obstetrics and Gynecology): 35 persons
c) Emergency cases: 35 persons
d) Surgery: 23 persons
e) ENT : 10 persons
f) Others: 26 persons
g) Total: 196 persons

(4.5 percent of the total patients visited)

2. Table of maternity and child health service

A. Maternity Service

a) Prenatal service: 129 persons
b) Registration of pregnant woman by percentage
3 month of below : 4.9%
3-6 months : 38.0%
7 months above : 20.1%
c) Number of prenatal services rendered
1-2 times : 26.4%
3-4 times : 42.6%
5 times above : 31.0%
average: 3.6 times
d) Breakdown of the type of prenatal service rendered
1) Weight check : 62.0%
2) Blood pressure check : 98.4%
3) Urine check : 82.4%
4) Blood type check : 51.9%
5) Physical examination : 31.0%

B. Type of assisted person attended for the delivery

Type of person attended	Year 1976	Year 1979
Physician or midwife	14%	24.7%
Community Health Worker(CHP)	0%	16%
Older mothers or mothers-in-law	86%	59.3%

C. Number of Postnatal Cases by Type of Specialist

a) By Health Worker

Number of service time	Year 1979
1	7%
2	32%
3	24%
4	12%
5	6%
Average : 2.7 times	

b) By Other than Health Workers

	1976
Physician	5.2%
Herbalist (doctor)	1.6%
No Postnatal Care	73.6%
Gun Health Worker	0%
Others	19.6%

* Number of postnatal services in 1979 were rendered by Community Health Workers or midwives.

D. Table of vaccination or innoculation for babies Between the Ages of Six Months and Three Years

Year / Type of vaccination	76 (%)	79 (%)
B.C.G.	78.7	93
D.P.T.	65.1	91
First time	-	11
Second time	-	19
Final	18.1	70
Polio	82.1	76
First time	-	22
Second time	-	19
Final	32.1	59
Measles	32.8	35

3. Table of Family Planning Services Rendered

Type of services	Year 76 (%) 4.009	Year 79 (%) 7.054
Oral pills	10.0	10.9
Loop	13.4	18.7
Condom	3.2	5.1
Vasectomy	2.7	13.1
Other	6.2	10.2
	35.5	58.0

G. Evaluation Approaches to Health Workers Performance

Prof. Kyong Kyun Chung
School of Public Health
Seoul National University

To begin with, one has to clarify a few key factors illustrated follows:

1) Objectives of evaluation
2) Target of evaluation
3) Method and scale of evaluation
4) Who evaluates
5) Using the results of the evaluation

In order to observe the above items properly, it may be necessary to clarify, in depth, various relevant factors associated with them, one by one in detail:

1) Objectives of Evaluation

Objectives of evaluation can be further classified with regard to following purposes in order to conduct the evaluation:

a. For the purpose of making decisions or determining the direction of program installation
b. For program continuation and clarification
c. For program modification
d. For information collection in support of the program or to criticize the program
e. Here again, for the purpose of analytical evaluation of health worker's performance, one has to also take the following relevant factors into consideration:

   1) Promotion of workers performance
   2) Guidance
   3) Training
   4) Retention
   5) Role modification or role change of the worker

2) Target or Goal of Evaluation

In considering the target or goal of the evaluation, one has to keep in mind that it is always better to tackle it from both the vertical performance evaluation, as well as the horizontal performance evaluation.

This is because health worker performance can be greatly influenced by such factors as relevant program leaders, organizational impact, environmental or managerial factors of various vertical hatures.

It is also worthwhile to pay attention to evaluative factors closely related to the health workers supervisory officers, as well as the performance of her junior subordinates deployed at the grass root level.

3) Method and Scale of Evaluation

An evaluation of the health worker's performance again can depend considerably upon the method and scale to be applied for evaluation approaches.

The scope of the health workers job is greatly varied and the scope of work is very broad. Therefore in order to evaluate a worker's performance of their job description, the measurement scale must also be broad.

For instance, one activity or one performance can be greatly different in its nature and time consumption as well as its substancy; an example is the case of baby delivery attendance, compared to the case of an emergency patient's care, or one shot of vaccine, or medicine issued for a cold patient.

It may be very safe to assume, therefore that in the approach to a health worker's performance, the result can be better achieved if the evaluation can be treated individually by type of service rendered. For instance, such an individual type of performance can be illustrated as patient treatment, patient referral, laboratory test, maternity and child health, T.B. control, disease prevention and administrative office work. For all these individual activities, it is also indispensable to develop an appropriate measurement scale to be scientifically applied for actual evaluation processes.

A situation similar to this evaluation of the health worker can be better interpreted by the case of a middle school student whose achievement in English or mathematics is either outstanding or very poor due to some underlying reason.

In the case of student evaluation with regard to English, one can attribute the success or failure as to the teacher's skill or the student's learning capability, as well as to teaching tools and facilities applied when instruction is performed.

4) Who Evaluates

Nature and interrelationship attributed to evaluator can be classified and illustrated as follows:

	Financially dependent	Financially related	Financially independent
Administratively dependent	1	2	3
Administratively related	4	5	6
Administratively independent	7	8	9

As can be seen from the above diagram, greater contrast can be observed from Factor No. 1 to Factor No. 9.

In the case of Factor No. 1, it may be of the self-evaluation type; therefore, it may have more strength or success and self-centered results or factors.

As a conclusion, Factor No. 9 may be a fairly independent approach because it can be done by on outside academic research institute or experts from colleges.

From these extreme relative factors, it is safe to assume that perhaps the approach of Factor No. 5 may be the most appropriate method to recommend for the ideal evaluation of health worker's performance.

5) Use of the result of evaluation

Since evaluation itself requires considerable expense to conduct, it is necessary to plan in advance the best use of the results of an evaluation. It is often observed that evaluation reports no matter how costly, are kept at or circulated only in central agencies for the exclusive use of policymakers.

It can be suggested, therefore, that evaluation results should be widely circulated for not only central staff but also middle-level supervisors, as well as field-level health workers and relevant academic schools or institutes, for an ultimate evaluation of the activities of the organization and management of the health workers organization itself.

Summarized paper to the above talk as an appendix

Prof. K.K. Chung

1. Why do we evaluate ?

   1) To contribute to decisions about PROGRAM INSTALLATION
   2) To contribute to decisions about PROGRAM CONTINUATION, EXPANSION, or CLARIFICATION
   3) To contribute to decisions about PROGRAM MODIFICATION
   4) To obtain evidence favoring program to rally support
   5) To obtain evidence against program to rally opposition
   6) To contribute to the understanding of basic processes

2. Various General Methods of Investigation

   1) Test scores
   2) Questionnaire or interview data
   3) Logs, diaries
   4) Observations
   5) Ratings
   6) Clinical or Case Study
   7) Records
   8) Social indicators
   9) Expert opinions
   10) Chance encounter, informal contact, testimony

3. Who evaluates ?

	Financially dependent	Financially related	Financially independent
Administratively dependent	1	2	3
Administratively related	4	5	6
Administratively independent	7	8	9

3. Case Report

A. Case Presentation - Maul-Geon-Gang Saup (Village Health Program)

by Kang Kyung-Lan
Hyoryong Myon Health Subcenter,
Gunee Gun

For eleven years that began in September, 1950, I worked at the Army Medical School and the Army Hospital. For a while thereafter, I was employed at the Daegu Nurse's Training School until July, 1966, when I was dispatched to Viet Nam as a member of the Korean Medical team. I served at Vung Jau, Viet Nam for about two years. Upon completion of two years of service, I returned and resumed my job at the Nurse Training School.

In July, 1977, I attended a twelve month Community Health Practitioners' training course in order to take part in the Maul-Geon-Gang Saup (Village Health Program) which was then implemented by the Korea Health Development Institute. I chose this career because working in doctorless villages had been my long-cherished desire. I judged that the time had come for me to devote myself to such a job, but it was really a difficult decision for me to make, because I had many other duties to do, such as a housewife, mother, and eldest daughter-in-law of my family. It was really hard to leave my home behind and proceed to the rural post of my new assignment.

As a result of continued desire on my part, and the cooperative attitude on the part of my family members, I was able to participate in the program. Fortunately, my children were old enough to take care of themselves. After the completion of a six month regular training course at the KHDI, I attended the six month practical training course conducted at Gunee County. In January, 1978, I was officially assigned to Hyorong Myon Health Subcenter, Gunee Gun.

Hyorong Myon, the post of my new assignment, is located between Taegu City and Andong City, about an hour's drive from the former. Having 1,521 households or a population of 7190, it produces apples and onions as its major agricultural products. An average annual income per household stands at about ₩2,000,000. There is one middle school and four primary schools. Hyoryong Myon, consisting of 25 administrative Dongs, is very scenic and has clean, fresh air.

The Village Health Program is a part of the Saemaul Health Program. When compared with the Saemaul Movement, which was initiated in 1970, the start of the Village Health Program was rather late in timing. What I felt all the more keenly sooner after my arrival, was that there must be still countless villages with no doctors throughout the country. The community health program is designed to develop a comprehensive system

which delivers low-cost, good quality health care services to such rural populations deprived of such benefits.

Before I go into the details of the activities of the village health program, I would like to describe briefly the situation as it was before the program. About ten years ago, one community physician was assigned to the Health Subcenter, but he quit five months later. Hyoryong Myon has had neither a hospital nor clinic, only a pharmacy. Accordingly, any patients suffering from minor ailments depended upon the pharmacy for immediate relief from pains, and other serious patients had to be sent by taxi to Taegu or Gunee for emergency treatment. Before my arrival, there were three nurse aides working at the Health Subcenter at the Myon level in the capacity of maternal and child health worker, family planning worker and tuberculosis control worker, respectively. They were administratively placed under the direct supervision of the chief of the Myon, and even their time and attendance record was maintained at the Myon office. For this reason, their activities in the health care services were not well received. In its 20 pyong office space, there was nothing but two desks and two chairs. Upon my arrival in January, 1978, I found the construction of a new Health Subcenter building had just started. A neat looking building with 20 pyong floor space was completed in May of the same year. The new Health Subcenter is equipped with an examination room, administrative office, loop administration room, night-duty room, kitchen, storage room and water supplies, all of which are quite an improvement as compared to the previous facilities.

Five health workers, including myself, are presently assigned to the Hyoryong Myon Health Subcenter. Of these, two health workers work at the Primary Health Post which is an extension post of the Subcenter and is located at Ochon-Dong and one tuberculosis control worker and maternal and child health worker are assigned to the Subcenter. Two health workers of the Ochong Dong Health Post consist of one multipurpose worker (nurse) who is the director of the Post, and one family planning worker who is a nurse aide. Administratively, the Myon Health Subcenter covers seventeen Dongs and the Ochong Dong Primary Health Post is in charge of the remaining eight Dongs. The establishment of an extension post at Ochong Dong offers a great convenience to the residents in neighboring villages for obtaining needed primary health care services, without spending time and effort to travel a long distance to the Health Subcenter.

Now I am going to touch upon the activities of the health practitioner.

1. Functions and Roles of Health

The functions and roles of the health practitioner are diversified and wide in scope.

As part of the role in community development, the health practitioner is required to attend the community gatherings and meetings of all kinds in the capacity as head of one local organization. Such events include the Civil Defense unit Meeting, Ban-Sang Hoi (Neighborhood Association Meeting), community organizational meetings, Women's Organization meeting, Myon Health Development Committee meeting, and banquets for the aged, etc.

Of these, the Myon Health Development Committee meeting discusses the matters falling under the jurisdiction of the health practitioner. The Committee meeting, chaired by the Myon chief, is regularily held at two month intervals at the Myon office.

The constitutent members of the Hyoryong Myon Health Development Committee are composed of heads from each community organization at various levels, one delegate of the National Conference for Unification, and the female owner of the Myon rice mill. I find the Committee meetings to be a very productive and a valuable vehicle in carrying out the village health program. Through this mechanism, the purpose, intents and activities of the village health program are widely disseminated to the villagers, and necessary advice and assistance is sought from them. All the attendees show a keen interest in our activities. At one meeting, members requested that we disinfect school wells, and made inquiries of vasectomy procedures. On one occasion, I gave the attendees a full account of the benefits and needs of a vasectomy, as part of my effort in promoting a family planning program. Upon returning to his office, the head of a certain organization strongly urged his staff members to cooperate fully with the vasectomy program. The members are all prominent figures of the local community. I can usually obtain from each of the possible assistance needed in carrying out our duties in the Primary Health Unit. They frequently express a sense of relief and gratitude for having their own Health Subcenter in their community. I can see that they now feel they can bring up their children safely.

The villagers' increasing confidence in the work of the Health Subcenter and their rewarding comments on our performance usually renew our sense of duty and determination in the hope that their expections should not be betrayed. They are so considerate as to see that any recommendations made at the Committee meeting are heard by the responsible organization at the higher level.

2. Preventive and Curative Aspects of Health Care Services

Although disease prevention activities were carried out even before the village health program was introduced into Hyoryong Myon, the curative services were totally non-existent. Presently, the delivery of the primary health care service is made much more effective, and the patients, classified into three categories, are referred to the community

physician according to their classification. Three classifications denote the health care delivery system, comprising of the primary health unit (primary delivery), Health Subcenter (secondary delivery) and hospital (tertiary delivery). Due to the absence of transportation in the area, we have to depend on taxis or trucks that pass by for patient referral. Accordingly, we find the referral of a patient falling ill at midnight to be very difficult.

Once, the Russian influenza was widespread throughout the country. Hyoryong Myon was no exception to the epidemic. At that time, of 600 primary school kids, some 350 were afflicted with the flu. With the medicine supplied by the Gunee Health Center at our emergency request, we could help the afflicted children. The clue which led us to identify the flu patients was the daily visitation to the Health Subcenter of the school children who suffered from similar symptoms. The community organizational heads' meeting was accidently held then at the Myon office.

At the meeting, the headmaster of the Hyoryong Primary School expressed his grave concern over the increasing number of absent children. At my inquiry, he said about one-third of the total school children were absent, and furthermore the number of ill children would total more than half. It was really shocking news to me. My immediate reaction was that the school must be closed for a while or that certain first-aid measures must be taken to take care of ill children and keep the flu from further spreading. So I picked up the phone right way and asked the Gunee Health Center for immediate assistance. On that afternoon, a team comprised of the Chief of Health Sub-section of the center, his staff, and director of Dr. Oh's Clinic which is the primary medical clinic, visited the school.

Sick children, in groups of five to six at a time, were called into the headmaster's room for Dr. Oh's diagnosis and prescription. The medicine supplied from the Health Center was provided in a two day dose to 350 patients. I felt quite relieved to see that our combined efforts resulted in a sharp decrease in the number of absentees. Afterwards, the headmaster made a personal visit to our Health Subcenter, bringing with him ten bottles of Bacchus (a nutritious drink) as a token of his gratefulness for what we did. Aside from this, at the Ban-Sang Hoi (Neighborhood Association meeting) held subsequent to this incident, all the villagers attended showed me their pleasure and admiration. This event made wide publicity among the residents that the medicine doses distributed by the Health Subcenter were very effective in getting rid of influenza. As a result, 20-30 patients per day rushed into the Subcenter for consultative and curative services.

In the barley harvesting season, quite a number of middle school boys visited us for treatment, with their hands and feet bleeding with

cuts from a sickle. Therefore, we have to prepare more suturing material and curative supplies during barley and rive harvesting seasons than during the rest of the year.

As you can realize, the medical examination and treatment, prescription, maintaining of records, administering of injections, preparaing the clinical reports, etc., is all work done only by myself.

According to the statistics last year, the number of the patients registered in Hyoryong Myon is 5,783; 5,196 general patients and 587 recipients of the medical aid program. This reflects that all the community members, with the exception of 2,000 persons made at least one visit to the Health Subcenter. Medical consultations and medicines are offered by the government at no cost to the recipients of the relief program and to the indigent people who are entitled to treatment with their medical relief cards. However, the utilization rate by the people in this group of the Health Subcenter's services is very low, primarily because of their misunderstood belief that the card-bearing patients would receive poorer service and a cheaper quality of treatment compared with the ordinary cash-paying patients.

Of the total patients, 40% complained of respiratory problems, 30% of disgestive disorders, and another 20% complained of eczema. The high rate of eczema is attributed to the life mode and living conditions, such as taking baths in the river in the summer, and rarely bathing their bodies in winter, simply because no bath facilities are available. Especially, serious eczema is especially conspicuous among infants and school children. In most cases, the eczema is completely cured in one week with proper treatment, including injections and medication. When patients and their parents thank me after the eczema-affected and scabs are completely cured, I find myself thinking it is worthwhile working for these people. The remaining 10% accounts for parasite patients, those suffering from external wounds, high-blood pressure, etc.

As a part of my routine activities, I visit villages far from the Health Subcenter four times a month. I also make trips to the Primary Health Post at Ochung Dong to give them a hand. Naturally, as the health practitioner, I am obliged to be away from the Health Subcenter. From time to time, some patients come a long way by taxi on one of these off-days. They get disappointed and angry on the off-duty days at the Health Subcenter. Of course, I take all possible precautions to make advance public notice that every Tuesday, except on market day, the health practitioner will be away in the field. However, villagers do not seem to give heed to this advance notice, and they just grumble. I was told that in this case, they walk in a pharmacy and simply buy some medicine at a cost two to three times higher than the one charged by the Health Subcenter.

In fact, villagers expect us to work all week, without taking a day off. Indeed, people may fall ill at any moment, including holidays, but it would be appreciated if they would be a little more thoughtful to the health workers. In my case, I am away from home every weekday. I think I am entitled to a weekend off to be with my family. It is rather disappointing to see that people want us to do things only for their own convenience. And yet, the Health Subcenter is not adequately staffed, and we cannot afford to have night and day shifts.

When I give a patient an injection, I get nervous at the thought of the patient collapsing due to the side-effects of the shot. It is said that, even in private hospitals, no one likes to administer an SM injection. For a health practitioner like me, who has no governmental license and no legal guaranty for possible risks, it becomes even more difficult to give an SM and other injections. Fortunately, there has not been a single case of any ill-effects from the shots I have given, but who knows when bad luck might befall me? It is true that, now and then, patients die from the ill-effects caused by an injection of 5% glucose, even in private hospitals or general hospitals equipped with modern facilities and experts. We have to keep in mind that one case of failure does completely offset 99 cases of success.

On market day which is every five days, many patients rush in at the same time. As soon as they step into my office, they, without exception, demand immediate care and treatment, by saying that they are extremely busy or there is not much time left for them to catch the next bus, and so forth. The price of medicine is much cheaper than that available at a local pharmacy. We supply inexpensive, good quality medicine at purchase price without adding any profit margin. I am sure that the Health Subcenter's medicine is one-fifth the price of the pharmacy medicine. For this reason, a great number of villagers who used to utilize the pharmacy now visit us.

3. Maternal and Child Health Program

The MCH program is one of the most important activities we perform. Our duties include: identifying pregnant women in each village; having them register with the Health Subcenter; attending the deliveries; and providing pre- and post-natal care. I and one maternal and child health worker make frequent home visitations. Aside from the activities mentioned above, two days per month are designated as the MCH clinic days. On such days, we check health conditions of pregnant women and new born babies, and administer vaccinations of various kinds.

We give a five day advance notice of the date, hour, and place of the MCH well-baby clinic, and the types of vaccination to be given on that day. Then the village head (Dong Chief) announces the information through the village loud speaker. Also, we health care workers remind every mother of the MCH clinic day whenever we see them in the village. Through this mechanism, we gather together the pregnant women and infants on the MCH clinic day.

Home visitations are made regularly for the pregnant women: once a month for those of up to 8 months pregnant; once every two weeks for those who are 9 months pregnant; and once every week for those entering into the tenth month of pregnancy. On the MCH clinic day, their blood pressure is measured, urine examined, and weights measured. These data are recorded in the pregnant women's record.

On this day, the director of the Community Health Center visits us to directly examine the expecting and nursing mothers, as well as new-born babies. If any abnormality is found, he immediately prescribes action for them according to his diagnosis. In the case of infants, mothers are requested to bring with them an infant card. After we measure weight, head girth and height for entry into the card, the baby is turned over to the director for examination and the vaccination scheduled for the date. Additionally, we health workers demonstrate how to prepare a weaning diet.

4. Family Planning

Family planning is a national program to curb the population growth rate, and this is also one of the health care programs on which we place much emphasis. To effectively carry out a family planning program which is an integral part of the village health program, a family record sheet was prepared by each household. The impression I obtained during the sheet-preparation process, by visiting each house, was that there is something wrong with the attitude of the rural population as far as family planning is concerned. They begin to seriously consider family planning only after they give birth to as many as seven daughters. The sheer and strong desire to have a baby boy finally ends up with a large sized family. Family planning is totally ineffective to such people.

In the past, the use of oral contraceptives, condoms and loops was recommended. In these days, however, we stress the ovarian tube and vasectomy operation for permanent contraception through sterilization.

Strangely, women in rural communities are quite willing to have the contraceptive operation themselves, by insisting that their husbands should be kept away from the surgery. It is really difficult to understand them. The reason may be either that women are strongly attached to a Confucian idea of "Predominance of man over woman" deeply rooted in the rural society, or that there are not many devoted husbands. The attitude and behavior of the rural women can be taken as the expression of their pure affection to their husbands. However, such a negative attitude certainly poses a problem to family planning workers, because we have an annual target number of vasectomy cases to attain.

In conclusion, the rural population lacks the understanding of the merits of vasectomy. They think the vasectomy operation would enervate the male population with regard to doing hard farming work.

I become helpless when they refuse to have an operation on such groundless reason.

They don't realize that, even without having the vasectomy operation, a man would gradually grow weak and incapacitated for hard work, as he gets older. To make things worse, people easily give their ears to such biased views. Even educated people keep asking us why they should bother themselves with a surgical operation while effective and simple contraceptives are readily available these days. In conclusion, changing the perception of rural population regarding vasectomy, and helping them to accept it, is the most difficult issue in the family planning program.

5. Anti-Tuberculosis Drive

For early detection, we collect and examine the sputum of potential consumptive patients. However, villagers are not cooperative with us in this regard. They attempt to keep the fact hidden from their neighbors as much as they can.

6. Health Education

The Health Education program is presently conducted by dividing target groups into two: one for general residents and the other for school children. Due to the traditional life mode and habit coherent to the agrarian community, we don't expect that the program will produce any immediate, tangible effects or benefits. The people don't think much of our repeated instructions to clean their hands, drink boiled water, etc. They simply lead their life in the way the are accustomed to. They think that dirt and dust are no matter of concern, as they live on and work the soil.

On one occasion, a physical examination was conducted for primary school children. To our shock, a majority of the children with the upper garments removed, had much dirt on their bodies. So we scolded them for their dirtiness, and told them to take a bath as soon as they got back home. It is disheartening, however, to know that this instruction will never be carried out, simply because the Myon does not have a single public bath facility, nor households do not have adequate facilities for bathing. Taking a bath in the winter is next to impossible.

Indeed, the Saemaul Movement (Community Development Program) transformed the traditional thatched houses into tile-roofed, or western style houses. However, people who live in these improved houses still persist in their traditional way of life which they led previously in the thatched houses. Though the exterior appearance looks very neat, the rooms inside are still dirty and swarm with flies.

7. Epidemic Prevention

With the exception of rainy days, disinfectant sprays are are applied around the villages every evening. Some housewives ask, out of greed, for more liquid be sprayed around their own houses. At any rate, villagers are very pleased when flies and mosquitoes are killed or eradicated.

8. Other Administrative Works

We are also required to perform a great deal of administrative-type of work. This includes health administration, handling of official letters, and preparation of various monthly or weekly reports. At the end of each month, we have to prepare bills for payment of medicaid expenses for the recipients of the government's liveihood relief, together with the monthly activity report from each field.

9. Conclusion

In my opinion, the KHDI's health demonstration project is an innovative and indispensible program, but its starting date should have been sooner. This type of program should have been put into effect much earlier. To date, the rural population has been born and brought up in doctorless villages. They are destined to die with no access to medical care at all, when they become aged, weak and sick. The situation is almost identical to that of the high mountain tribe (Montana Tribe) in Viet Nam, where I worked for two years. Now that our GNP has grown to the highest level among the developing countries, the rural populace is entitled to a decent human life and to the equal sharing of medical benefits. Undoubtedly, the government is presently striving very hard to discover a way for improvement. Nonetheless, we field health workers would like to request health experts and policy planners to give their strong efforts to finding ultimate solutions for improving the rural health situation. People say that the countryside is beautiful; the air is fresh through out the year; clean water runs down the streams; cicadas sing in the summer time; and in autumn rice paddies turn into a golden field waving in the wind. To those living in cities, all of these may sound very romantic and poetic. However, when you get down here, you will find the situation is far from being all beautiful.

As soon as day breaks, people run to the fields to work the earth until sunset, in order to keep from starving.

Their sun-tanned faces look almost like those of negros. Their hands and feet get chapped and are hardened as stone. It is a very pitiful sight.

No country would be strong and rich, if it were not based on a strong and rich rural community. I think more attention should be given to the development of the rural society than to that of the cities.

It is also highly desirable that an effective support system be explored in order to motivate and stimulate the field health workers to continue rendering health care and medical services for an extended time. None of you can think that medical doctors, who have an extravagent amount of schooling expenses for degrees, and nice-looking nurses would volunteer to work in the countryside, isolated and remote from modern civilization and material comforts, for the rest of their life. I think that the improved treatment and other incentives for health workers, in terms of compensation and personal status, should come first before anything else.

In fact, our personnel status and jobs are not guaranteed. Our positions are classified as Grade 8, Miscellaneous Jobs a category equivalent to the status of an office boy in each county office. We are temporary employees with no legal guaranty for a future career, and we don't have the benefits of severance payment. We simply carry out a community health care program associated with the KHDI Demonstration Project. Absence of legal basis for our medical examination and MCH management makes our daily activities very risky and makes one nervous.

If we are to succeed in our efforts to reduce the number of doctorless villages through the primary health care program, the field health workers should be granted the appropriate licensing so that they can continue to work with professional pride and confidence. And at the same time, if health workers perform their duties with the spirit of self-sacrifice and dedication, we are bound to see the fruit of our present endeavour in the near future; that is, no doctorless villages and a healthy rural community.

Lastly, I hope the village health program will be as successful as the Saemaul Movement.

Thank you.

B. Case Presentation of Implementing Maul-Geon-Gang Saup

Woo, Man-Soo
Community Health Practitioner
Jangpyong Primary Health Unit
Hongchon Gun

Located in a deep mountainous area, Jangpyong Primary Health Unit (PHU) is farthest from the road network in Gangwon Province, and locate 40 kilometers from the seat of the Hongchon Gun office, and 25 km from that of the Myon office. Buses, which are the only means of transportation in this area, make five round-trips per day. This village has neither a herb medicine handler nor a drug store, and therefore the residents receive no medical benefits unless they visit the seat of the Gun office.

The area has a population of about 2,650 persons with 472 households, and five administrative Rees (village). A majority of the residents engage in farming. It has two primary schools and two branch schools, in which 450 school children are enrolled. It also has two churches.

Upon graduation from the Chuncheon nursing school in 1975, I attended a one year midwifery training course which granted me with a license of midwife. Thereafter, I served for about one year at a private hospital at the community's health center.

I succeeded in the selection examinations for the community health practitioner which was developed and conducted by the Korea Health Development Institute (KHDI), with a firm intent to participate in improving the health of rural residents. After one year of training, from July 1st, 1977, through June 30th, 1978, I was officially dispatched to the present primary health unit.

The Jangpyong Primary Health Unit is staffed with one Community Health Practitioner (CHP), one Community Health Aide (CHA) and one clerk a secretary. These three health personnel assume all duties including maternal and child health care, medical care service, tuberculosis control, family planning, health education, organizing of the rural community, and induces them to participate in establishing the Dae-Dong-Hoe and manage its membership fees. The Community Cooperative Health System (CCHS- Dae Dong Hoe) was organized to provide convenient and low-cost health care service to the entire community, and to improve the health level of the community people. The system is composed of an honorary president and a general-secretary who were elected from the community residents and who a salary of 56,000 won. His main job is to manage the fees and to coordinate primary health unit and the community affairs. A resident is eligible to be a member of the Dae-Dong Hoe if he pays 1,500 won as an admission fee. A membership card is issued to each member, who is then entitled to health care services at the primary health unit (first level care), Gun community

health center (secondary level care) and private or general hospital (secondary-delivery system). Under the system, the co-op member is compensated for 15,000 won of medical costs (ten times that of the initial admission fee) in case of surgery or hospitalization. Due to the relatively high initial payment of the admission fee (for example 7,500 won in case of a five-member family), the residents were at first very hesitant to participate in the co-op program. With continued pursuation on our part, however, a total of 1,436 persons or about 50 percent of the community residents joined this Dae-Dong Hoe as of February 28th, 1979. Of these members, 805 persons visited our primary health unit for medical consultation or treatment, 58 patients were referred to the community health center for further treatment, and 26 patients were using the government-sponsored medicaid benefits.

On the average, about 25 persons visit our primary health unit per day for physical examinations, prescriptions, administering of medicine, counseling, paperwork arrangement, etc., chiefly for disorders of the digestive organs and neuralgia, with a few cases of emergency deliveries or external wounds.

The Jangpyong primary health unit uses a wide range of medicines which includes up to 66 different kinds. The unit is equipped with such medical instruments as hemoglobin tester, delivery kits, urine tester, loop sets, ear speculum, nasal speculum, equipment for external would treatment and suturing, hemadynamometer, stethoscope, refrigerator, sterilizer and others. With all the equipment, we provide health and medical care services for the community residents.

Actual performance for the past six months from January to June 1979 were as follows:

First, the number of new and old patients handled at this unit amounts to 1,914 persons, comprising chiefly of chronic gastritis and neuralgia of the diseases of the digestive system.

Second, the number of patients referred to the Gun health center is 45, consisting mostly of those needing chest X-rays and medical examinations of female diseases.

Third, the number of medical care by home visitation at the request of the community residents amounts to 45 cases, of which most of them are digestion disorders.

Fourth, preventive medical services were provided to 775 persons. These included prenatal care with examination and postnatal care of pregnant women, vaccinations, and counseling of tuberculosis patients.

In addition, regular health education was conducted six times, benefiting a total of about 600 persons. Six cases of direct deliveries

were also attend to.

Once a month, counseling services on maternal and child health, family planning and tuberculosis are being provided.

Twice a week, Tuesday and Thursday, the Primary Health Unit (PHU) is opening only in the morning. The afternoon time is allocated for home visit to patients, and the Maul-Geon-Gang mother's club for enlightenment activities.

The following are the community development activities and preventive health care activities.

We, the health workers of the community health practitioner (CHP), community health aide(CHA) and village health agent(VHA), always attend the mother's club meeting, where we conduct education on prenatal and postnatal care, the need for control vaccinations, family planning, tuberculosis, etc., by showing slides. The meeting usually is attend by 30 to 40 women.

Also included in the education are sanitary living methods, prevention of diseases, and home treatment methods.

Because I am a licensed midwife, I can attend deliveries under a legally guaranteed status. However, these cases are hard to supervise for other health workers without midwife licenses. It would be very helpful if attending delivery cares by other health workers were legally assured, by granting them with licenses of qualification, when they complete the community health practitioner's training courses.

The following points are some of the constraints observed and the recommendations made on the basis of the experience in the field during the past year:

First, the three month training period at the hospital was rather short for assuming medical care services for community residents. A one week supplemental clinical training course for every two-three months of service to the community residents would be highly desirable to enhance the service quality of the existing community health practitioner.

Second, an effective system must be established to assure speedy and simplified requests supplies of medicine and other instruments and tools.

Third, it usually takes more than six months for a primary health unit to get requested supplies due to a budgetary problem and the complexity of purchase procedures. Support must be extended to the operational expenses.

C. Case Presentation Maul-Geon-Gang Saup (Community Health Project)

Kim, Yong Ae
Okgu Myon Upo Community Health Center
Okgu Gun

Previously, I was deployed to Eochongdo-ri Primary Health Post, Eochongdo Island, Mi Myon, Okgu Gun, Jeonla-buk Province. The Island is a five-hour trip by passenger boat from the Gunsan pier on the mainland. Among the inhabited islands in the Yellow Sea, it is the closest to mainland China.

Upon graduation from the Kae Jeung Nurse's Training College in 1971, I worked at the Health Center in Okgu Gun until 1977, when I applied for the selection examination to be a community health practitioner(CHP), new type of health worker, which was conducted by the Korea Health Development Institute(KHDI). Upon completion of a six-month training course (three months of theoretical course and three months of clinical practice), I was dispatched on Jan. 4, 1978, to the Primary Health Unit on Eochong Island to do field practice of the community health project for the islanders. The Island has windy and foggy weather throughout the year, with little rain even in the summer. Thus, the inhabitants always suffer from an insufficiency of potable water. The population is made up of about 1,200 persons or about 300 households, and has poor natural resources.

One of my initial jobs was to visit key members of the island's community, such as Chief of the Ree administration (village); Leader of New Village Development Movement; Officer in charge of the police post; agent of the island's drug outlet; head of the telegram and telephone facilities; medic officer of the Navy detachment to Echongdo and evangelists, including the "quack" doctor (unlicensed physician). When meeting with these key individuals, I introduced myself and explained the role and function of the community health practitioner and the scope and the activities of the community health project on the Island. At first, most of the key personnel I encountered seemed to be disinterested in my story.

With a sense of duty, I made home visits to the villagers in order to prepare family health record files, check overall environmental sanitary conditions and living conditions, including the needy target population in the services of maternal and child health, tuberculosis control and family planning. During home visits, I also made sure that anyone in the house requiring simple medical care treatment or health consultation should come to see me at the primary health post which had just been set up.

It took me more than two months to complete the family health record files, because many islanders are frequently away from their homes for a long period of time visiting relatives on the mainland or fishing.

With regard to the age structure of the inhabitants, about 50 percent of age 50 or older; 20 percent in the 20 to 49 age brachet, and 30 percent age 20 or younger.

A passenger boat was the only means of transportation between the island and mainland. Three times a day, telephone calls were available through the police station, but poor reception of the wireless set did not result in effective communication.

The primary health unit was equipped with the following basic medical supplies; hemadynamometer, stethoscope, clinical thermometer, syringe, applicators, dressing kit, medicine for simple treatments, delivery kit, scale for infant, height scale, and weight scale for adults.

Under an overall health care service plan prepared on the basis of data which collected from the health center and that of the locality (primary health post), I began to give comprehensive primary health care, including simple curative services, environmental sanitation and health education.

In order to improve the relationship with the defense forces personnel on the Island, I visited their barracks and gave lectures on family planning, fundamental knowledge of health, and especially on the preventive aspect of venereal disease.

The preventive innoculations conducted during the ten month period from January to October 1978 included the following:

Cholera vaccinations were administered to 190 persons including sailors from other areas, which was a 120 percent accomplishment over the target number: that of typhoid fever to 750 persons or 80 percent; D.P.T. to 79 percent; D.T. for humans; and polio vaccination was given to 60 persons, or 110 percent over the target number. Encephalitis vaccination was also administred to 70 persons, or 90 percent of the target. In the activity of family planning, 54 percent of fertile married women were given various types of contraceptives. Health education was given to a total of 1,616 persons including students, and 520 home visits were made during the above period. Although some 150 sputum samples were collected, due to the lack of storage facilities, accurate examination was not conducted, and therefore, it was suggested that the primary health unit be equipped with a microscope with the necessary attachment in the future. Through the sputum test and indirect check or X-ray checkings, 34 tuberculosis cases were detected.

The disease pattern of the island's patients are as follows: respiratory cases accounted for 30 percent of the total, the digestive disorders, 20 percent, skin diseases, 15 percent, external injuries,

10 percent, venereal disease, 10 percent, and others, 10 percent. The high V.D. rate was derived from the large portion of sailors stationed on the island.

To this date, about 65 percent of the residents visited the primary health unit to receive medical examination or simple medical treatment.

On a continuing basis, health education was conducted for the residents through Ban-Sang-Hoi (neighborhood association meeting), covering such subjects as ill-effects or misuse of medicine, general symptoms of contagious diseases, preventive measures and medical treatment, family planning, and also the safe handling of agricultural chemicals or insecticides.

Once a month, a circuit hospital ship, operated by the Gunsan provincial hospital, visited the island. Since it sails to adjacent islands after a day's anchorage, the islanders do not receive sufficient benefits from the services of the hospital ship.

The Upo community health center where I am assigned at present, seated in Upo Myon, the largest Myon in Okgu Gun, covers nine administragive Rees (villages) having a population of 23,394, or 4,189 households. On an average, I receive 10 patients a day. Twice a week, I travel to make home visits.

Some of the constraints encountered while serving at Uchong Island are as follows:

First, a greater portion of the health worker's time is consumed in meeting numerous reporting requirements, thus leaving less time for providing primary health care services.

Second, more administrative supports must be provided. Delivery of medicine and other supplies for instance are always delayed because of the lack of transportation. A small size refrigerator should be provided to store various vaccines safely.

Third, present rransportation and communication systems must be improved. In the case of an emergency referral patient, it is difficult to conduct prompt reporting or transportation of the case to the mainland health center.

Fourth, the employment status of health workers who are serving at remote islands must be legally guaranteed as permanent positions.

In summary, the Government must pay more attention to providing positive supports, so that we health workers on islands can perform our duties with increased pride and a sense of duty.

D. Case Presentation of Maul-Geon-Gang Saup

Lee, Kyong Ae
Sanseung Primary Health Post
Uiheung Myon, Gunee Gun

In 1977 when I graduated from the Taegu Nursing School, Gunee Gun was selected as one of the comprehensive health demonstration project sites.

Comprised of nineteen administrative Dongs, Uiheung Myon has a population of about 6,850, or 1,386 households. It is located within two hours of Daegu City, and one hour from Gunee Gun Health Center. About 80 percent of the total population engages in farming, and family the number per household averages 4.8 persons. An average annual income per household by the sale of agricultural products such as apples, onions and garlic amounts to 1.9 million won. There are two primary schools and one middle school in the area. The only medical facilities available in this Myon are one drug store and two herb medicine shops. When an emergency occurs, the patient has to be sent to the private clinic, 12 km away from the Myon, and a good quality medical care is hardly expected by the community residents due to the transportation problem.

Beginning in July 1977, a multi-purpose primary health care services started, concurrently with the initiation of Maul-Geon-Gang Saup (Community Health Project) in this community.

Upon appointment as health worker in July, 1977, I took a two month training course with other community health aides: one month for theoretical training for multi-purpose health services at the Medical College of Gyongbuk University, and one month for practical training on home visitation and community health care service at Yongin Gun.

Staffed with two health workers including myself, Sanweong Primary Health Post began its operation in September, 1977, serving some 300 residents in ten Dongs. Our post is equipped with a hemadynamometer, weight scale, height scale, equipment for vaccination, and medicine necessary for first-aid treatment.

Many villagers were suffering from diarrhea, and I was told by the village health agent that there is no proper water supply facility. I collected a sample of water from the well, and referred it to the Gun Health Center. Many bacilli were found through examination. In collaboration with the village health agent and local the Saemaul leader, the village wells were sterilized. In the meantime, I conducted enlightenment training on kitchen sanitation and well chlorination on behalf of the Mothers' Club, explaining the cause of diarrhea by contaminated drinking water, unsanitary dish-cleaning cloths and a

dirty environmentee. From this day, the first Sunday of each month was set up as "clean-up day" by the members, especially around sewers and homes.

In order to better provide health services and to more accurately understand the health condition of the residents, I prepared a family health folder for each house, in which the data and information regarding new born babies, pregnant women, tuberculosis patients, status of family planning and environmental sanitation are described in detail. I also collected data on pregnant women's blood pressure, urine tests and weight measurement, and detection of any early stage abnormality, and referred them to the community health center when necessary.

Two days of each month are designated as maternal and child clinic days. On these days, the Director of the Community Health Center himself sees the new-born babies and pregnant women for physical check-ups and for appropriate treatment, and also refers those requiring a vasectomy to the hospital by ambulance.

To this date, a total of 1,970 patients have visited our primary health unit. Of these, some 80 emergency cases were referred to the community health center for further treatment.

The following constraints were observed:

First, due to very low salaries and lack of permanent security for the position of health workers assigned to the primary health unit, the health workers (in a temporary employment status) are not able to actively participate in health care services.

Second, in order to implement multi-purpose activities, it is highly desirable to conduct a midwifery training course for us, and to grant appropriate qualification or license, so that we can attend to delivery care with legal assurance.

Third, supplemental training is desirable to enhance the quality of health worker so that they meet the increasing needs for better health services by the community residents.

Fourth, administrative paper work such as preparing reports must be reduced, so that the health workers can better concentrate on their primary role of providing health care services to the community residents.

E. Case Presentation of Maul-Geon-Gang Saup

Huh, Kyong Ja
Community Health Aide(CHA)
Dogwan Primary Health Unit
Hongchon Gun

Naechon Myon is located on a remote mountain, 32 km northeast of Hongchon Gun, Gangwon Province. The Myon has a population of 5,489 persons, or 476 households, comprised of eight administrative Rees (villages), or 78 natural villages. Being the sole doctorless Myon in Hongchon Gun, Naechon Myon has two primary schools. Approximately 90 percent of its population engages in farming and an average annual income per household amounts to 1,985,000 won. Neither preventive health services nor health promotion services were in existence before the Community Health Project (Maul-Geon-Gang Saup) was initiated in the Naechon Myon area. The only services the residents could seek was acupuncture by the local herbalist. People's awareness of the role of the primary health unit was naturally very low.

Since Hongchon Gun was selected as one of the Korea Health Development Institute's health demonstration project sites, community health care programs received great attention by the people. Naechon Myon was divided into two areas; each area with its own primary health unit(PHU) to which the specially trained community health practitioner (CHP) was assigned. We three CHA health workers perform integrated primary health care services (tuberculosis control, family planning and maternal and child health) for residents of four administrative Rees.

Accordingly, I take care of the four Rees, which includes 392 households, 21 natural villages and 2,542 persons. The previous Health Sub-center was modified to the present primary health unit with one curative service room and one consultation room. The first job I undertook was to organize the community health mother's club as well as to prepare family health record folders of the villagers. Organizing the mother's club was particularly difficult primarily because of conflicting interests with similar organizations already existing in the community.

I distributed booklets and leaflets describing basic health information to visiting residents to our center. In our area, infant mortality was very high because appropriate preventive measures were not taken. It was quite fortunate that Naechon Myon was designated as one of the comprehensive health demonstration project sites at this juncture.

I kept emphasizing the need for organizing the community health mother's club. Mrs. Yoo, Eum Jon, who is with the spirit of strong self-sacrifice and high moral, was selected as the first chairperson of

the club.

The twentieth day of every month is set as the date for the regular monthly meeting, on which we, the health workers, pay visits to each village to listen to problem cases of the community health programmes with the lessons of success or failure learned from them.

In summary, the community health project brought many benefits to the community residents within the area.

Described below are some of the more outstanding benefits resulting from the health programme:

First, by performing multi-purpose primary health care services in each area, it has become much easier to render service and care for infants and pregnant women.

Second, preparation and maintenance of a family health folder by individual households enabled the health workers to effectively carry out services through the home visitation activities.

Third, due to the limited area of coverage and jurisdiction, it was quite easy to note the number of residents moving in and out of the community the registration of infants and pregnant women has also been much easier than before.

Fourth, the integrated implementation of the three areas of health service programmes (tuberculosis control, family planning and maternal and child health) enabled us to more easily identify the problem areas needing improvement by the exchange of relevant information among the three CHA's.

Fifth, by encouraging operations of tuballigation at the time of delivery, the family planning programme has attained better results.

Some of the problems beyond my control while participating in the community health care activities in this area are briefly summarized below.

First, with the increased responsibilities as an integrated health worker, the control and management of various equipment and supplies is likely to become somewhat burdensome without an administrative clerk in charge of them.

Second, the quantity of various records and ledgers has increased tremendously (25 records with regard to three integrated health programmes and 10 other general ledgers).

These records must be simplified or or reduced as much as possible so that more time is allowed for health care services.

Third, in order to update the quality of the health workers, supplemental education or training in the overall aspects of the health field is highly desirable.

Fourth, for successful implementation of primary health care service programmes, the employment status of health workers must be changed from a temporary status.

F. Case Presentation

Maul-Geon-Gang Saup (Community Health Project)

Kim, Jeun Sook
Community Health Aide (CHA)
Daeya Community Health Center
Okgu Gun

For the past three years, I have served as a Community Health Practitioner at Yeon Island, one of nineteen islands on the shore of the Yellow Sea, about 50 km from Ginsan City. This island is rather small, and has a population of about 400 persons, the majority of whom are engaged in fishing.

Upon appointment as the island's health worker, I took the community health aide's orientation course at the Gun Health Center in Okgu Gun. As a Community Health Aide(CHA), I was officially deployed to Yeon Island to participate in the comprehensive community health service project.

At the Primary Health Unit(PHU), an unforgetable and sad thing happened one night during my first month of duty which disappointed me very much. About midnight, when I was sound asleep, I was awakened by someone violently knocking on the door. It was a young couple with a little girl.

The child was very sick and had a high fever. I immediately checked her temperature, and found it was nearly forty degrees. I could do nothing for this poor girl who appeared to be suffering from some unidentifiable communicable disease, from which she died on the same night. I was very shocked. As a community health aide, my duty is strictly limited to medical care. All I had with me were a few tubes of ointment and mercurochrome for external treatment, some medicine for indigestion and vaccinations which were for preventive use.

A few weeks passed, and I was told by the health center that there would be a CHA orientation on the community health project in Daegu City, Gyeongsang-Buk province, and it was recommended that I attend the eight week course.

As soon as I returned from the above training course, I started home visits in order to prepare family health record files. At each visit, I spent ample time making close observation of personal status, environmental factors, living status and disease prevalence. The about two months later I collected sputums, forty-five cases in about two weeks. However, it was impossible to refer the collected sputums to the health center on the mainland in a timely fashion because the

passenger boat was so often out of order. Later, when these sputum specimens were sent to the center, thirth-eight were already bad and only eight were acceptable.

One day, a girl ran in our health unit and said that her father was vomiting bloody saliva at home. I managed to arrange an emergency boat and referred the sick man along with his daughter, to the health center in the city.

After thoroughly checking sputum and X-ray, the man was identified as a far-advanced tuberculosis case. Previously, the tuberculosis patient had been treated by a "quack" doctor on the island who diagnosed his case as bronchitis.

Afterwards, three members of the family were registered as TB patients at the center, and received medical treatment. Two of the three have now recovered from the disease. Twelve other cases in the village were also referred for further treatment.

I attended a number of newborn deliveries before becoming a CHA. I once worked an obstetrician's clinic and had experience in attending deliveries. I did my best as a multi-purpose health worker on the services related to tuberculosis control, family planning, maternal and child health, and as a community nurse aide for the improvement of the health of the people in the island community. I helped sterilize the fishing boats often at the request of the fisherman.

Problems identified during my service of the islanders are as follows:

First, it is highly desirable that the health workers be officially appointed as permanent employees, so that they can perform the assigned duties with zeal and confidence. Also, allowance for isolated areas should be granted to them to improved the morale of the island health workers.

Second, in addition to one existing nurse aide, one community health practitioner(CHP) should be deployed to each island, so that the preventive and curative primary health care services can be effectively provided to the residents of each island.

Third, a refrigerator or ice box should be supplied to store innoculative vaccine and collected sputa.

G. Field Activities of Village Health Worker

Mrs. Jong-Ja Kim
Gunee Gun Seungsan Myon

Bonglim village, where I am serving as a Village Health Worker, is located about one km away from the Bonglim railway station. The general standard of villagers living there is low compared to other areas, and a far more traditional cultural heritage is deeply rooted there, as compared to adjacent villages.

Being a predominantly agricultural community, this village has approximately twenty-two hectares of rice paddy, about ten hectares of upland, with a population of 220 persons who are engaged in agriculture. As for educational background, more than 90% of the male population can read and write Korean, whereas nearly 80% of female population can not even read Korean. The result is many illiterate citizens.

However, this backward situation is gradually improving through the active implementation of the Saemaul movement by which the productivity of farmers, installation of television sets improvement of sanitary facilities, as well as social education programs are increasingly being developed.

Prior to the implementation of the Saemaul (New Community) Development movement in our Myon (Township) there was not a single drug store or even health service center. Naturally, the health and sanitary knowledge of the villagers was very low, and therefore sick people were well accustomed to relying on a few herbal medicines.

In order to get a medical doctor's consultation or treatment, a patient has to travel by train or by bus for two or three hours to go to Young Chun Eup or Eusung Eup, the capital cities of the adjacent counties.

The number of train passing by the station near our village is only two per day. Therefore, an emergency patient has to rely on private taxis or temporary transportation.

As far as I recall, about five or six years ago a few aide-nurses were placed in the Myon administrative office and they were supposed to take the responsibility of family planning, maternity care, and child health care, along with TB control.

Only health care workers were placed in the Myon, and their scope of activities were rather limited. Therefore, a sanitary program, minor curative services and health education for the people were beyond of their reach, other than FP, TB and MCH services. Even the family planning program, in spite of its development in our country, appeared

to be rather shallow in its inpact, perhaps due to the predominant male supermacy ideology and lack of understanding by married women in general, plus the complicated implication of the loop and tuballigation processes. As an educated village woman I observed the existence of so many problems in our community which so many villagers are trying to overcome. As I myself was struggling to do something good to help our neighbours, a few village housewives called on me one evening and asked me if I would take over the role of chairperson of the Village Woman's Association.

Since those elder village women who requested me to chairperson of the association so eagerly sought my leadership, I could not find any reason to refuse their request so I finally decided to accept.

Since I had made up my mind to dedicate myself to the betterment and development of our community, I found that there were many things to do as development leader along with activating the service of the Village Woman's Association.

First of all I had to educate members of the association through regular meetings with them, because of so many problems associated with their living standards, as well as their lack of awareness about health and sanitary conditions.

I also spent time looking through old records and official letters previously handled by the other chairpersons of the Village Woman's Association in order to acquaint myself with various village programs and development projects carried out in the past.

At the same time I updated old and started new individual family records, including information about family income resources, as well as land holdings and the educational background of villagers in our community.

Whenever I had a chance to go to the Myon Capital, I managed to meet the Myon chief and his key staff and had discussions about the Saemaul Development Program, as well as other current problems related to our community development.

Whenever I had a chance to visit health centers, I also had discussions with the staff about family planning programs, sanitary programs and health education for our village people in order to collect information for myself get help. In this way I thought I could widen my scope of knowledge and collect better information related to the overall development of our community affairs.

One day in the autumn of 1977, I received good news from the village chief, informing me that the Maul-Geon-Gang Saup (Primary Health

Health Care Service) had been implemented in our county and Myon.

Soon an official letter reached our village requesting the recommendation of one Village Health Worker to the County Health Center immediately. The village chief officially recommended me to be appointed as the Village Health Worker.

In a few days I was further informed that I should report to the health center for orientation training as the village health worker at the Gunee Myon (County Capital Town) training center for two days.

The contents and topics covered in this orientation training were as follows; the Role of the Village Health Worker, emergency care and aid, maternity and child health care, family planning program, TB control program and environmental hygiene, as well as other development-related subjects, such as Saemaul Undong or community housing program.

Upon returning to my village, I immediately began home visitation to those households whose family heads were less enthusiastic participants in the development of the village community programs, which included health care matters.

I urged their active attendance of village association meetings and various educational gatherings to be held in the future in our community.

In a few months, after a painstaking drive to stimulate and motivate them for the common endeavour of development, practically 95% of the total households signed their registration to the Village Woman's Association.

The first community development campaign tackled under my leadership was to reinforce some basic community renovation programs, including such household projects as listed below:

a) Roofing renovation with tiles (work done mainly by village men)
b) Fence renovation (")
c) House-gate repair or renovation (")
d) Renovation of kitchens, fireplaces, and cooking stands (work done through women's contributions)
e) Toilet renovation or reconstruction and kept at a distance from the main house (work done through women's contributions)
f) Improvement of domestic savings drive (work done through women's contributions)

With a couple months of hardwork and the all-out efforts of the villagers, we were able to attain quite remarkable achievements in

those target-projects; thus, our upgraded village development level is that of a self-help status.

Our next community development project target was to build a Community Cultural Center. Because of the enormous material and labour investment, many villagers were at first rather reluctant to approve this project proposal.

Through my initiative, many young housewives joined me in carrying stone graval from the nearby hills to make the walls and fences of the cultural center before village male folks started to work for the project.

The reason why I thought this cultural center project is important was that it can be used as temporary clinical center for not only pregnant mothers and ordinary patient but also monthly village baby-clinic when community health practitioner visited the village, and also can be used as daily necessary commodity store.

A few months later the village cultural center was completed and an administrative telephone facility was installed with the help of Myon Chief.

The convenient use of the telephone was beyond our best imagination, particularly when an emergency patient reported in our village. In that case, an immediate request for help to the community-health-aide station in the Myon office could be make.

By this time, public attention and interest about the community health center staff has become increasingly stronger thus regular village visits by the health center staff became a routine part of the schedule for the health center people.

Having established a stronger link with the County Health Center as "Maul-Geon-Gang Saup" Project area, we were able to enjoy various benefits, including the distribution of emergency first aid drugs, virmicides water chlorinates, and X-ray services which were conducted for the first time for all the villagers.

On the other hand, I have cooperated as much as possible in keeping the family health card record files, set up by the Community Health Aides of the Myon Health Sub-center. It was the first time since our birth in this village that files have been kept, and we found that these cards are very good "Signal Indicators" for all women on how to cope with family planning, or even MCH services and relevant education to be appropriately conducted. Following the completion of the individual family health card, we then completed pre-natal women's card, registration cards, and baby registration cards made so all Health Workers would automatically know when and what actions should be rendered for them.

It was a novelty that I, as a Village Health Worker, would write a note introducing a village woman who wished to go see a doctor or Community Health Practitioner for consultation to the health center physician or CHP in our County. In this manner, I have performed my role as a health care communicator between the Health Center and our village.

When helping with the family planning services, there were a number of situations which I had to think through very carefully. One woman, who was secretly using oral pills, was discovered with them by her mother-in-law, who was strongly against birth control. Even the woman's husband did not know she was taking them. In the case of this family, they felt I was to blame. I think that it is of the utmost importance to conduct thorough education for family planning which should include all household members concerned, not just the woman alone.

To my surprise, there are still parents who think the idea of having more children is a way of creating more sources of income for their household in the future. Some parents would not cooperate with the family planning program even after they had eight children.

In this particular case of the parents suggested to us again how hard it is to carry out a successful education program for health care and family planning in our communities these days.

Having served quite intensively for some time with the family planning program, we were able to attain our target-goal during 1978 much earlier than in other villages, and thus, I was given an outstanding merit award by the president of the National Family Planning Association at the end of the year.

However, I frankly have to admit that there was a very weak aspect in the developmental sectors; namely, it is with the sanitary sector which requires our increased attention beginning early in 1979.

We, the association members, resolved to do our utmost in the environmental sanitation drive; namely, toilet facility improvements, domestic animal pen cleaning, and maintenance of the community laundry center, as well as a village lane clean-up campaign.

Another obstacle in working with our villagers was their attitude of expecting free services or free drugs which was a deeply rooted problem among the village people. They think that anything that is given by the government health center can be nothing more than a free hand-out.

Because of this conventional attitude of the villagers, many health workers had to spend a lot of time educating then in the idea of the "fee-for-service" principle, and this caused considerable difficulty in

initially implementing medical cooperative programs.

As a concluding remark, I would like to point out that one of the most important tasks for the health workers to tackle is launching a steady health educational program, taking every possible occasion in the village, such as Ban-Sang Hoi (neighbourhood monthly meeting), Women's Association meetings, Saemaul Youth Association meetings and Ree Development Council meetings held in the communities. Also other public gatherings, such as primary school pupil's meetings, market day meetings and baby clinic day meetings, these are the kind of meeting resources for which every possible health education effort should be reinforced.

H. Field Activities of Village Health Worker

Mrs. Kang Yoon Soon
Okgu Gun, Kae Jong Myon

Adong Ree Village, where I live, is located about seven km away from Koonsan City. Fifty-three households (33 farm households and 20 non-farming households) are located there with about sixteen hectares (an average of 0.5 hectares per household) of arable farm land that is much smaller than the national average farm landholding, which is 0.95 hectares.

Ever since Saemaul Undong (new community development movement) has been implemented in this village, the affairs of our village have been drastically changed; however, many stagnant factors remain, accompanied by dynamic development the remaining factors are as follows:

a) A deep indulgence in wine drinking
b) Card (whatoo) playing for money
c) Too much individualistic or egoistic attitudes of living, and uncooperative manners
d) Extreme laziness during the winter season, people do not work because of the cold

I came to live here in this village about six years ago with my husband who is a teacher at a primary school. At that time my husband's salary was far too small to meet our needs, so I was tempted to look for some other source of income.

One day I saw for technical specialists of the County Rural Development Guidance Office.

They taught me a number of ways to boost our income sources, mainly from the agriculture and livestock farming some of their suggestions are:

a) Cultivate a better variety of rice (highbreed IR 667)
b) Feed the hogs better on an improved livestock ban
c) Cultivate better cabbage with P.V.C. in the seedbed the year around (sales to be expanded to Gunsan City)

A few years of hard work with those innovative methods of Rice culture, vegatable field and livestock farming, we were able to build up a fairly good capital income. As an immigrant country farming couple, we did quite well, and thus became a somewhat rich farm household in a few years with the concentrated effort of both myself, my husband and his two brothers.

In the spring of 1974, the chief of Myon administration, after having consulted with the Ree (administrative unit of villages) chief, asked me if I was interested in serving as a chairperson of the Saemaul Women's Association. I accepted the offer after receiving the consent of my husband. Having strengthened the cohesiveness of the Women's Association, I proposed to launch, a saving-drive for a year to make a capital fund of one million won with which we could start some capital development projects for the Association.

It worked out well and we were able to save the amount of one million won with which we purchased a better breed-stock of hog, (yorkshire) and distribute them to interested livestock farming households in the village. We also encouraged farmers to plant early cabbage with the grant-assistance of this community fund. Thus, we have undergone the initial phase of paving a way for tight cohesion of the members of the Women's Association through a number of such a income-producing projects.

One day in early the summer of 1977, there was an outbreak of an unknown disease in our village and one victim soon died after relying exclusively on medication from the village drug store. Later we discovered that it was a typhoid-type of communicable disease for which drug store alone cannot cope with. Many people, including the heads of the household, were so ignorant they did not know why their beloved brother was suffering or what type of communicable disease it was, and depended only upon the village pharmacist.

Soon, the rest of people in the village had proper immediate treatment from the doctor and some of the healthy people had innoculations for the disease from the County Health Center.

All the villagers were vividly impressed by the situation and came to realize the need for health and sanitary protection to live as healthy human beings in this rural area for the first time in the course of the village history.

At this time, I found out from the County Health Center that our county, including all the villages and myons, was selected as a Demonstration Project Area of the Primary Health Care Service (Maul-Geon-Gang Saup) for a five year period by the Korea Health Development Institute, beginning in 1977.

We also knew that there would be one community health center established in a centrally accessible location to serve the population on an average of two myons. A doctor or a specially trained community health worker (a minor substitute doctor-type trained worker) would be deployed to serve with some curative and preventive services for the people in rural areas with affordable costs to them.

Thus, I paid my first study visit to one such a community health center set up earlier in Daeya Myon and found that there was a ready-to-serve out-reach clinic set up at the grass root community level. There I found also a very impressive poster with the slogan, "Good health is your most precious property which, if you lose it, you lose all the world, including wealth, honour and happiness."

Not long later our county chief appointed about one hundred of us as village health voluntary workers in the whole county on the recommendation of the Myon and Ree chief, and gave a short day-long course of orientation training at the county office, we were then given a small handy "manual" of village health work published by the Korea Health Development Institute.

Having returned from this orientation course, I noticed, with renewed ideas, that there are so many problems which require solutions or eradication in our living environment.

One problem was the fact that there were too many flies and mosquitoes annoying us, perhaps due to some extent to too many hog-pens and chicken-pens, as well as the enormous number of compost-manure heaps so rapidly introduced with the Saemaul Movement Development Projects.

Since the Saemaul Movement Development Project has contributed very much to the overall development of rural communities, including gross productivities and other infrastructural investments, it has some accompanying adverse side-effects as far as sanitation. All villagers had to tackle a wholesome campaign against the eradication of flies, mosquitoes, and rodents with the technical help of a sanitation specialist's staff from the County Health Center.

We also resolved to set a regular monthly date for the village sanitation campaign, with the consent of Village Development Council monthly meetings.

At the general monthly meeting of the Village Women's Association, we adopted a priority project slogan for the four following targets:

1) create a village with a reinforced preventive health campaign
2) adopt family planning plan for all
3) reinforce maternity and child services
4) reinforce the use of virmicides for all.

In March, 1979, we decided at the Woman's Association meeting to launch a parasite eradication campaign. Thus, I urged them to collect stool specimans and had them sent to the County Health Center for microscopic test and as a result found that 98% had round worm, 36% had ascariasis and the rest had pinworm and hookworm.

At the subsequent Women's Association monthly meeting, the result of the laboratory tests were announced and many kinds of vermicides were distributed for them to use immediately.

In this manner, I found it very useful to educate them with the actual results of the parasite data. As a result of this demonstrative educational effort, the parents of all the parasite-infected children have used the vermicides and attained remarkable results.

In the spring 1979, our village was designated as "Health Guidance Demonstration Village" in the Myon and, because of this selection, we were given two gallons of DDVP to disinfect the surrounding environment. The village cleans the entire domestic environment, through the help of the 4H Youth Club members every week and thus we have greatly improved our environmental sanitation.

In conducting the family planning program, I thought it may be an effective example that my husband and I be the model family planning couple, so with the consent of my husband, I was the first to have a tubal ligation.

From this day, I have always quoted my family as an example whenever I talk on the issues of the family planning program in the village. As a result of an eight month continued education program, more than two-thirds of the married (child-bearing age) woman came to adopt some method of contraception.

Everybody in the village can still recall the sad story about an older delivering mother's death because of delivery complications, which shows that they did not have proper peri-natal care in the olden days.

Having achieved some tangible results in family planning, our efforts then concentrated on giving more pre-natal care to pregnant mothers, including regular checks and nutritional feeding for the mothers-to-be, along with various innoculations and tests to be given to the babies once they were born.

In the light of my experiences in working with the Village Women's Association, I would like to propose that the County Health Authority expand the training opportunities for village leaders, including key association members, with regard to health and sanitation problems and family health issues in the future. I would like to also propose that there should be some functional sub-division regarding the scope of work of the association, including: Family Planning function, Maternity and child health, preventive and sanitary function, and nutrition and education, so that the Women's Association can better function in the future.

I. Field Activities of Village Health Worker

Mrs. Bok-Soon Chang
Hongchon Gun, Seu Myon

Soongok Village is located about ten km from the Myon (township) center and fifty km from the county capital city, Hongchon. It has a population of 434 people, with 67 households.

Transportation facilities to the myon capital are not developed, and we go to the myon office on foot for birth registrations or other business. It takes four hours by bus to go to the county office.

Being such a remote village, one can imagine the backwardness engulfing the inhabitants with regard to educational, agricultural and health sectors,

Among the generation over 50 years of age, it is hard to find any men who have even graduated from elementary or middle school, while most young men have no more than an elementary school education. The knowledge of health and sanitation is, needless to say low because the general standard of education is so low.

Therefore, the parents of a child who is sick with measles an appendicitis are bound to lose their child before they can reach a doctor because they live so far away.

People in this village are accustomed to bearing and living with simple sicknesses or diseases when the symptom is minor. Therefore, village people were very happy to see that a primary health care post was being set up for their villages and that the Dae Dong Hoi medical cooperative was implemented for them. It was at about this same time that many chairman of the village woman's association, including myself, were appointed as Village Health Workers (VHW) in August, 1978. About two months later a village health worker orientation course was conducted for three days in the capital city of the Gun, and topics of orientation training covered were as follows: role of village health workers; introduction to village health program; how to conduct a village education program; what to do when an emergency is reported in the village; how to apply simple dressings and nursing care; and the use of simple drugs.

After the training was over, I was given a certificate, letter of appointment and a uniform from the county chief and we all returned to our home villages. This was how our role as village health worker started. I had a talk with the village chief and requested his help in calling for a villager's meeting in which I gave on introductory speech to people about how the village health program would be carried

out, and how the village could benefit from the village health service, as well as my role as the village health worker.

From thus point on, I did my best in administring various health programs through mothers and other village woman, as well as by making home visits. I tried my best to share my knowledge, limited though it was, with mothers who were rearing children, and stressed the need for vaccinations and inoculations through daily home visits. At times I also simple instructions to pregnant mothers. I issued aspirins or antacids to people who were in need of them, but I was always very careful to advise them to see a CHP or doctor at the community health center if their symptom persisted. I also visited the health center in the capital city of the county one time and received some water chlorinates for water purification of village wells.

I then again requested the village chief's help in calling for a meeting of villagers so that I could conduct an educational campaign on the need for water purification. After all the wells in the village were chlorinated, I was severely criticized my the village people by their complaints that they could not drink the water because of the smell of chlorinates which they were not accustomed to. In order to get the village people to clean their surrounding environment, including the toilet, waste-disposal point, and compost manure heap, I solicited and requested at a village meeting that they adopt a monthly community cleaning day. The decision was then unanimously adopted at the village meeting.

After a few months of serving as the village health worker, many people called at my home asking for antacids for their stomachs or for APC or aspirin for their family member's future use, even if they were not presently suffering from anything. It was not an easy job for me to refuse such simple requests for medicine because they were either relatives or beloved neighbourhood people with whom I had lived for many years in the same community. Furthermore the stock of the drugs was very scarce. In this particular drug distribution situation there exists a conspicuous need to conduct a health education program for a conventional drug-saving attitude of the people.

My daily life as a health educator does not end with drug issues only, but also entails dealing with housewives in convincing them of the need for spacing child by the use of contraceptives, and tuballigation with regard to the family planning program. One of my routine daily jobs was to keep a diary of my activities as a village health worker with regard to drug issues and a record of villagers visiting me daily and as why they came to see me.

Although this diary may seem a very trivial matter from a professional standpoint, it has a very significant meaning in reviewing

the various villager's health record during the month, and it makes one feel very proud when one carries it to the monthly health worker's meeting held at the County Health Center. As compared with services of other village health worker, the average number of people I helped during the month was about ten people with minor injuries and about thirty to whom I issued aspirin or antacids. One early morning in January, 1979, a housewife from the upper village knocked on our door and informed me that one of her neighbours was about to give birth and requested me to come with her.

Although I knew very little about a delivery I prepared to go with her. I telephoned the Community Health Practitioner who is stationed nearby before I left my home. As soon as I arrived at the home, I gave them very rudimentary directions, such as getting warm water really and preparing a bathing tray while we were waiting for the community health practitioner to come. I instructed the mother-in-law to prepare hot water, a delivery set-kit, disinfect scissors and thread, all of which must be ready to use when the baby is born. This delivery case appeared to be very difficult since the mother was 38 years old and it had been seven years since her last baby's delivery, however, to our suprise, everything was all right after about an hour of hard work on the part of both the mother and the Community Health Practitioner. One late afternoon in April, 1979, a man from a farm visited my health post with his finger cut by a sickle during field work. I had to give him a dressing with an emergency application of simple medication. Then, I advised him to go to the Community Health Practitioner stationed nearby at the Primary Health Unit immediately so that he could get further treatment.

Thus, villagers in our community gradually become aware of Primary Health Care Services rendered by not only our health post but also by the community health center as time went by, and they became far more cooperative toward my role of the village health worker.

During the initial service period I found a number of problems which I had to overcome and some of them are as follows: one of the difficulties which I faced was to serve at the same time, in a number of village organizations as an officer or chief, such as the Saemaul Womans' association chairperson, home improvement club chairperson, as well as village health mother's club leader while I also was a housewife and a mother of three children at home. My second difficulty was how to overcome conventional attitudes of older generations in the village who were against my active role in encouraging and persuading young woman to adopt various family planning.

My third difficulty was the fact that I had a very limited knowledge of health services whenever I had to face various complicated problems and questions of patients.

4. Program & Participants

A. Program

August 29 (Wednesday)

13:00-13:50 Registration

14:00-14:50 OPENING CEREMONY

Opening Remark
Dr. Younghat Ryu
President, KHDI

Congratulatory Address
His Excellency Mr. Sung Chul Hong
Minister, Ministry of Health & Social Affairs

Welcoming Address
The Honorable Mr. Sin Ik Kang
Governor, Cheju Province

Congratulatory Address
Mr. William E. Paupe
USAID Representative in Korea

FIRST PLENARY SESSION

Chaired by Dr. Younghat Ryu

15:00-15:40 KEY-NOTE SPEECH

"Role of New Health Workers in Primary Health Care Today"
by Dr. E Hyock Kwon
Chairman, Board of Directors, KHDI

15:40-16:10 "Selection and Training of New Health Workers"
by Mr. K. B. Yoone
Chief, Manpower Development Div.
KHDI

16:10-16:40 "Role and Function of New Health Workers"
by Dr. S. W. Lee
Chief, Health Project Division
KHDI

16:40-17:10 Question and Answer Session

17:10 GROUP PICTURE TAKING

17:30-18:30 Reception
Host: USAID Representative in Korea

August 30 (Thursday)

SECOND PLENARY SESSION

Chaired by Prof. Sung Kwan Lee
Gyeongbug University

09:00-10:15 "Case Presentations of Community Health Practitioners' Field Activities"

Case 1: by Ms. M. S. Woo
CHP, Hongchon Gun

Case 2: by Ms. Y. A. Kim
CHP, Okgu Gun

Case 3: by Ms. K. R. Kang
CHP, Gunee Gun

10:15-10:45 Question & Answer Session

10:45-11:00 Coffee Break

THIRD PLENARY SESSION

Chaired by Prof. Il Soon Kim
Yonsei University

11:00-11:30 "Expected Role of New Health Workers"
by Dr. J. Y. Cho
Chief, Public Health Section
Gyeongsang Bug Province

11:30-12:00 "Comparison between Existing Health Services and Maul-Geon-Gang-Saup"
by Dr. K. W. Han
Director,
Gunee Gun Health Center

12:00-12:15 Question & Answer Session

FOURTH PLENARY SESSION

Chaired by Dr. Yeon Chul Koo
Professor,
Ewha University

13:30-14:45 "Case presentations of Community Health Aides' Field Activities"

Case 1: by Ms. K. A. Lee
CHA, Gunee Gun

Case 2: by Ms. K. J. Huh
CHA, Hongchon Gun

Case 3: by Ms. J. S. Kim
CHA, Okgu Gun

14:45-15:15 Question & Answer Session

15:15-15:30 Coffee Break

15:30-16:00 "Review of New Health Workers' Activities on Consumers Viewpoint"
by Mr. S. T. Shim
Gun Chief, Okgu Gun

16:00-17:15 "Case Presentations on Activities of Village Health Workers"

Case 1: by Ms. Y. S. Kang
VHC, Okgu Gun

Case 2: by Ms. J. J. Kim
VHC, Gunee Gun

Case 3: by Ms. B. S. Chang
VHA, Hongchon Gun

17:15-17:45 Question & Answer Session

August 31 (Friday)

FIFTH PLENARY SESSION

Chaired by Dr. Jung Huh
Dean
School of Public Health
SNU

09:00-09:40 "Approaches to an Evaluation of the New Primary Health Care Workers Activities"
by Dr. J. H. Kim
Chief, Planning & Research Div., KHDI

09:40-09:50 Question & Answer Session

09:50-12:20 GROUP SESSION

Group 1: Community Health Practitioners' Role and Function, Training, Problems and Constraints, etc.
Chairman: Dr. S. K. Lee
Rapporteur: Dr. S. W. Lee, KHDI

Group 2: Community Health Aides' Role and Function, Training, Problems and Constraints, etc.
Chairman: Dr. Y. C. Koo
Rapporteur: Dr. S. I. Joo, KHDI

Group 3: Village Health Workers' Role and Function, Training, Problems and Constraints, etc.
Chairman: Dr. I. S. Kim
Rapporteur: Mr. C. H. Nam, KHDI

SIXTH PLENARY SESSION

Chaired by Dr. Chong Kee Park
Korea Development
Institute

14:00-14:30	Group Discussion Report (Group 3)
14:30-15:00	Questions and Answers
15:00-15:30	Group Discussion Report (Group 2)
15:30-16:00	Questions and Answers
16:00-16:20	Coffee Break
16:20-16:50	Group Discussion Report (Group 1)
16:50-17:20	Questions and Answers
17:20-17:50	"Assessment of Health Worker Activities" by Prof. Kyung Kyoon Chung School of Public Health,
19:00	Dinner Host : President, KHDI

September 1 (Saturday)

SEVENTH PLENARY SESSION

Chaired by Dr. Kyong Shik Chang
Director General
Bureau of Medical Affairs
Ministry of Health & Social
Affairs

09:00-10:00
1. Summary of Group Discussions
2. General Discussions
3. Recommendations

10:00-10:30 CLOSING CEREMONY
Presiding Dr. Younghat Ryu
President, KHDI

B. List of Participants:

Dr. Seung Hahm Park	Vice Minister, Ministry of Health and Social Affairs
Dr. E. Hyock Kwon	Chairman, Board of Directors Health Development Institute
Dr. Sung Kwan Lee	Professor, Department of Preventive Medicine, Gyeongbug University
Dr. Yun-Chul Koo	Professor, College of Medicine, Ewha Women's University
Dr. Hyung Jong Park	Professor, School of Public Health, Seoul National University
Dr. Jung Huh	Dean, School of Public Health Seoul National University
Dr. Hae Soo Lee	Permanent member, Korea Medical Association
Dr. Taek-Il Kim	Director, Korean Institute for Family Planning
Dr. Chong-Kee Park	Secretary-General, National Health Secretariat, Korea Development Institute
Mr. Chan Hong Moon	Director, Medical System Division Ministry of Health and Social Affairs
Mr. Hoon Shik Shin	Director, Third Medical Affairs Division, Ministry of Health & Social Affairs
Mr. Suk Chae Lee	Director, Fourth Planning Division, Economic Planning Board
Ms. Soon Ja Kim	Vice-president, Korean Nurse Association
Dr. Ha Cheong Yeon	Senior Researcher, Korea Development Institute
Mr. Jae Hyun Chang	Vice Chief, Hongchon Gun, Gangweon Province

Mr. Sang Jin Lee	Vice Chief, Gunee Gun, Gyeongsang Buk Province
Mr. Yong-Gyu Lee	Deputy County Chief, Gunee County, Gyeongbuk Province
Dr. Il Soon Kim	Professor, Department of Preventive Medicine College of Medicine Yonsei University
Mr. Dong Bin Jeon	Director, Public Health Division, Gangweon Province
Dr. Jae Yon Cho	Director, Public Health Division, Gyeongbug Province
Dr. Jung-Ok Park	Chief, Community Health Center, Hongchon Eup, Hongchon County, Gangweon Province
Mr. Kyung Kyoon Chung	Professor, School of Public Health Seoul National University
Mr. Jae Sung Min	Chief, Division of Research and Administrative Coordination, NHS Korea Development Institute
Dr. Young-Joon Ryu	Division-Director, Public Health Division, Jeonbuk Province Administration
Mr. Michael Park	Program Officer, UNICEF/Korea
Dr. Gwang Jae Lee	Director, Okgu Gun Health Center, Okgu Gun, Jeonra Bug Province
Dr. Gu Wung Han	Director, Gunee Gun Health Center Gunee Gun, Gyeongsang Buk Province
Mr. Byung Jun Lee	Officer, Saemaul Guidance Division, Ministry of Home Affairs

Mr. Sang Pyo Hong	Chief, Health Administration Section Gunee Gun Health Center Gunee Gun, Gyeongsang Bug Province
Ms. Kyong Ran Kang	Community Health Practitioner, Gunee Gun Health Center, Gunee Gun Gyeongsang Bug Province
Ms. Yong Ae Kim	Community Health Practitioner, Okgu Gun Health Center, Okgu Gun, Jeonra Bug Province
Ms. Man Soo Woo	Community Health Practitioner, Hongchon Gun Health Center, Hongchon Gun, Gangweon Province
Miss Gyeong-Ai Lee	Community Health Aid, Gunee Demonstration
Miss Gyeong-Ja Huh	Community Health Aid, Hongchon Demonstration
Miss Jum-Sook Kim	Community Health Aid, Okgu Demonstration
Ms. Yoone Soon Kang	Village Health Agent Hongchon Gun, Gangweon Province
Ms. Jeong Ja Kim	Village Health Agent Gunee Gun, Gyeongsang Buk Province
Ms. Bok Soon Chang	Village Health Agent Hongchon Gun, Gangweon Province
Dr. Younghat Ryu	President, Korea Health Development Institute
Mr. Chongmyun Chung	Secretary General, Korea Health Development Institute
Dr. Sung Woo Lee	Chief, Health Project Division, Korea Health Development Institute
Mr. Kil Byoung Yoone	Chief, Manpower Development Division Korea Health Development Institute
Dr. Chu Hwan Kim	Chief, Planning and Research Division, Korea Health Development Institute
Mr. Woo-Taek Chung	Chief, General Affairs Division, Korea Health Development Institute

Dr. Shyn-Il Joo	Invited Senior Researcher, Health Project Division, Korea Health Development Institute
Mr. Chul Hyun Nam	Senior Researcher, Korea Health Development Institute
Ms. Jin-Soon Kim	Senior Researcher, Manpower Development Division, Korea Health Development Institute
Mr. William E. Paupe	Representative, USAID in Korea
Dr. Alexander M. Rankin	Representative, WHO in Korea

Observers

Mr. Gun Bo Lee	Assistant Governor, Planning & Management, Cheju Province
Mr. Chang Soo Kang	Director General, Public Health Division, Cheju Province
Mr. Hong Jong Kim	Chief, Public Health Section Cheju Province
Dr. Hoo Yeul Yong	Chairman, Cheju Dental Association
Mr. Sung Kun Lee	USAID in Korea
Mr. Doo Jae Woo	USAID in Korea

Summary of Workshop Evaluation

1. The structure and organization of the workshop program?

	Number of Persons	Percentage (%)
a. Not so well arranged	-	-
b. Not well arranged	1	2.9
c. O.K.	3	8.8
d. Well arranged	20	58.8
e. Excellently arranged	10	29.4

2. The proceedings and procedure of the workshop?

a. Bad	-	-
b. Not so good	1	2.9
c. O.K.	3	8.8
d. Good	24	64.7
e. Excellent	6	23.5

3. How satisfied are you with the contents of presentation of health workers?

1) Community Health Practitioner

a. Not at all	-	-
b. Partially	-	-
c. O.K.	-	-
d. Completely	21	61.8
e. Very completely	13	38.2

2) Community Health Aide

a. Not at all	-	-
b. Partially	-	-
c. O.K.	1	2.9
d. Completely	23	67.6
e. Very completely	10	29.4

3) Village Health Aide

a. Not at all	-	-
b. Partially	-	-
c. O.K.	1	2.9
d. Completely	20	58.8
e. Very completely	13	38.3

	No. of Persons	Percentage(%)
4. How satisfied are you with the contents of presentation of others?		
a. Not at all	-	-
b. Partially	1	2.9
c. O.K.	6	17.6
d. Completely	18	52.9
e. Very completely	9	26.5
5. How satisfied are you with the plenary discussion?		
a. Not at all	-	-
b. Partially	-	-
c. O.K.	3	8.8
d. Completely	23	67.6
e. Very completely	8	23.5
6. How satisfied are you with the group discussion?		
a. Not at all	-	-
b. Partially	-	-
c. O.K.	-	-
d. Completely	26	76.5
e. Very completely	8	23.5
7. How free did you feel to participate and contribute in your group discussion?		
a. Not at all	-	-
b. Partially	-	-
c. O.K.	3	8.8
d. Completely	21	61.8
e. Very completely integrated	8	23.5
8. How do you think of the place of workshop?		
a. Not so good	1	2.9
b. Good	1	2.9
c. Better	23	67.6
d. Much better	9	26.5
9. How do you think, the best duration of the workshop like this?		

		No. of Persons	Percentage(%)
	a. 2 days	-	-
	b. 3 days	6	17.6
	c. 4 days	21	61.8
	d. 5 days	7	20.6
10.	The workshop atmosphere in general and place of boarding or living?		
	a. Bad	-	-
	b. Not so good	-	-
	c. O.K.	1	2.9
	d. Good	24	70.6
	e. Very good	9	26.5
11.	The outcome of workshop as compared to that of your expectations?		
	a. Not as good	-	-
	b. About same	2	5.8
	c. Better productivity	20	58.8
	d. Much better productivity	12	35.4
12.	Overall rating of the workshop?		
	a. Poor	-	-
	b. Fair	-	-
	c. Good	-	-
	d. Very good	20	58.8
	e. Excellent	14	41.2