한국농촌간호학회지 제3권 제2호(2008)
Journal of Korean Academy of
Rural Health Nursing
Vol. 3, No. 2. 2008

Key words : primary health care

Profile of Primary Health Care Post
- Focused on Saje PHCP in Wonju-Si, Kangwon-Do, Korea -

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This profile presents a brief overview of the past and current primary health care of Saje PHCP in Wonju Si, Kangwon-Do, Korea. I sincerely hope this profile will serve as a useful reference to help you better understand the PHC services of primary health care posts in Korea.

1. History of Saje PHCP

The Saje PHCP was started in 1983. There was no PHCP building in 1983 and primary health care services were started at a small rental house. The PHCP building was constructed in 1984 and reconstructed in 2004.

This report presents community characteristics, health status and community health practitioner (CHP) activities between 1986 and 2007.

2. Community General Characteristics in 1986

Wonju-Si is located in the center of the Korean peninsula and is southwest of Gangwon-Do. It is on the western side of the Taebaek Mountains, which are a major part of Baekdudaegan, stretching along the peninsula north and south.

- Size: 867.76㎢
- Population: 306,350(as of late 2008)
- Geography & culture: Wonju-Si has two rivers supplying water to the city: the Seom River starts from Taegisan Mountain, and the Namhan River stems from Odaesan. Wonju-Si is in generally flat area, but with numerous low hills. The city is blessed with great cultural heritage and many tourist attractions including Chiaksan National Park and Gangwongamyeong.
- Wonju-Si consists of 1 eup, 8 myeons and 16 dongs.

* Saje Primary Health Care Post

- Saje Primary Health Care Post is located in Heungup myeon. It takes 30 minutes to get to Saje PHCP from the Wonju city hall by bus.
- The Saje PHCP has taken care of 1,337 people (households; 327) in 4 RiS, 15 villages.
- The manpower in PHCP is only 1 CHP.
- Primary health workers are 1 community

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health practitioner and 15 village health workers. Their functions are focused on dissemination of health information and support CHP role. They are responsible for each village.

- There is a Saje PHCP operational committee that is composed of 24 villagers. The functions are to support for PHCP operation and ask for villagers' health needs.

1) Demographic characteristics

- About 7.1% of population were over 65 years old (About 2.7% of population were under 4 years old).
- The family structure was extended family as showing 88.1% and the average family members are 4.1.
- About 52.2% of population graduated from elementary school.
- About 93.0% of population was in agriculture.

2) Environmental status

- Piped water supply rate was 71.2%.
- Flushed toilet rate was 5.6%.

3) Health Status

(1) MCH (maternal and child health) services

- Contraceptive prevalence rate was 37.3%.
- Immunized rate of infants was 57.1% (87.3%, national data in 1988) of BCG, 64.7% (92.5%, national data in 1988) of DPT and 65.0% (87.3%, national data in 1988) of measles.
- Antenatal care rate was 5.1% and home delivery rate was 87.3%.

In the 1980's, the government started to promote MCH workers at each township, but results were lukewarm due to the prominence of family planning.

Comprehensive MCH services in rural areas have been provided along with the construction of MCH centers since 1983.

(2) Prevalence of disease

The prevalence rate of diseases was digestive system 29.6%, neurological system 21.2%, skeletal system 15.9% and respiratory system 10.6%.

(3) Utilization of PHC posts

- 70.1% of residents had the experience of using PHC posts.
- 88.1% of residents had felt the need of PHC posts.

4) CHP Activities

The various primary health care activities were provided by community health practitioner. Overall, nearly 60.0% of activities were curative services, 18.8% of health education and 12.5% of MCH services included family planning.

〈Table 1〉 Proportion of CHP(Community Health Practitioner) activities

Contents of activities	%
Curative service	60.0
Health education	18.8
MCH services & family planning	12.5
Management of TB	1.5
Environmental sanitation	1.3
Home visiting	0.5
Etc*	4.5

* meeting, clerk work, education for village health work, patients referral

Proportion of specific services on PHC activities were as follows.

(1) MCH services

Antenatal care services were provided 48.0%, postnatal care services were 27.5% and education for safe delivery were 14.7%.

Health education for child health was provided 49.6%, vaccination services were 24.7% and education for supplementary food was 23.8%.

〈Table 2〉 MCH services

Contents of activities	Specific services	%
MCH services (maternal health)	Antenatal care	48.0
	Delivery care	4.9
	Education for safe delivery	14.7
	Postnatal care	27.5
	Referral	4.9
Total		100.0
MCH services (child health)	Vaccination	24.7
	Education of supplementary food	23.8
	Health education	49.6
	Referral	1.9
Total		100.0

(2) Family planning

Counseling was provided 60.7% of target population, oral pill and condom were supplied 28.3 % of clients.

〈Table 3〉 Family planning (%)

Family planning	Counseling	60.7
	IUD insertion	3.8
	Oral pill & condom supply	28.3
	Referral(vasectomy & tubal ligation)	6.4
	Management of side effect	0.9
Total		100.0

(3) Curative services

Treatment and medication were provided 67.0% of clients.

〈Table 4〉 Curative services (%)

Curative services	Counseling	29.0
	Treatment and medication	67.0
	Referral	4.0
Total		100.0

(4) Health education

Proportion of health education was group education 59.1%, 23.9% was provided in clinic and 23.9% was provided in home setting.

〈Table 5〉 Health education (%)

Health education	Home visiting	17.0
	Group education	59.1
	In PHCP	23.9
Total		100.0

(5) Environmental sanitation

The problem of sanitation in housing was 68.0% and in drinking water was 32.0%.

〈Table 6〉 Environmental sanitation (%)

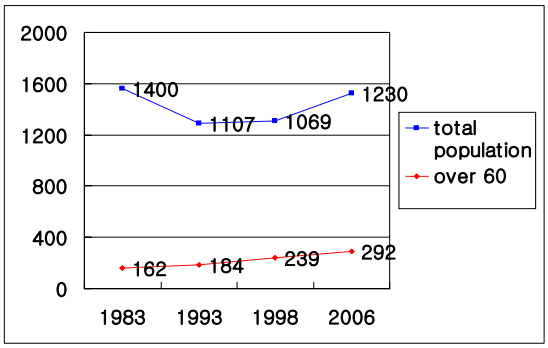
Problem of environmental sanitation	Drinking water	32.0
	housing	68.0
Total		100.0

3. Community general characteristics in 2007

- geography : 4 Ri, 15 villages, 1 apartment
- population: 1,230
- households: 410
  average household size: 3.0
- agriculture: 65.1%

1) Demographic characteristics

(1) Age distribution



〈Figure 1〉 Age distribution (Saje Ri)

The structure of the population is aging, and the percentage of the population aged 60 years and over is to increase from 11.5% in 1983

(over 65 years; 6.7%) to 23.7% in 2006 (over 65 years; 23.4% in Saje Ri/8.4% in Wonju city).

(2) Crude birth rate and Crude death rate

In the past, crude birth rate in Saje Ri was very low compared to the Wonju-Si and the whole country's crude birth rate, which was 0.3 in 1994, 0.08 in 2007. But, crude death rate in Saje Ri was very high compared to the Wonju-Si (5.6) and whole country's rate (5.4), which were 24.1 in 2007.

Primary cause of death is cancer (41.3% in Saje Ri, 26.7% in Wonju city, 26.3% in Korea).

〈Table 7-1〉 Crude birth rate (per 1,000)

	Saje Ri	Wonju Si	Whole country
1994	0.3	9.0	16.3
1999	0.2	12.2	13.2
2002	0.0	11.0	10.3
2007	0.08	7.7	9.0(2005)

〈Table 7-2〉 Crude death rate (per 1,000)

	Saje Ri	Wonju Si	Whole country
2007	24.1	5.6	5.4

(3) Family structure

There were rapid increate in the proportion of elderly in Saje Ri as compare to the whole country's average. So, the type of family structure was changed. The proportion of solitude the aged was 22.1% and 34.9% of aged family.

〈Table 8〉 Family structure

	Solitude the aged	The aged family
%	22.1	34.9

(4) Health Insurance

The coverage rate of health insurance was 95.0% and 5.0% of medical aid.

〈Table 9〉 Health insurance (%)

	Saje Ri	Wonju Si	Whole country
Health insurance	95.0	95.2	96.7
Medical aid	5.0	4.8	3.3

(5) Educational background

It is well known that the educational level can affect on income, social security, and it greatly contributes to the protection and promotion of health. The high proportion of residents (57.7%) had not received any formal education.

〈Table 10〉 Educational background (%)

	Saje Ri*	Wonju Si	Whole country
No school	57.7	6.8	6.3
Elementary school	23.7	21.1	27.0
Middle school	11.2	13.9	18.6
High school	6.6	33.1	33.9
Above college	0.8	25.1	14.2

* over 65 years

2) Environmental status

Healthy environments are one of the key factors for 'healthy living'. The 88.0% of residents in Saje Ri were supplied from piped water in 2007 (71.2% in 1986). The 58.0% of residents in Saje Ri eqipped flushed toilet in 2007 (5.6% in 1986).

〈Table 11〉 Environmental status (%)

	1986	2007
Piped water supply	71.2	88.0
Flushed toilet	5.6	58.0

3) Health Status

(1) Self-rated health status

Self-rated health status from a 2005 National Health and Nutrition Survey in Korea was found to be significantly correlated with older age, low education level, and blue collar work. This result is same as in Saje Ri. Self-rated health status was revealed about 2 times higher in negative response than whole country.

〈Table 12-1〉 Self-rated health status (%)

	Saje Ri	Wonju Si	Whole country
Not so good	33.2	10.9	17.6

(2) Prevalence of chronic disease*

The chronic disease of the residents experienced was the highest for arthritis (56.7%), followed by diabetes mellitus (10.9%), cardiovascular disease (10.9%) and gastric ulcer (8.1%).

〈Table 12-2〉 Prevalence of chronic disease(%)

Arthritis	Hypertension	DM	Cardiovascular disease	Gastric ulcer
56.7	31.8 (13.3**)	10.9 (5.2*)	10.9	8.1

* over 30y ** Wonju-Si, 2008

(3) Health behavior

People's life-style often includes unhealthy behaviors that pose health risks and cause various non-communicable diseases and injuries. 27.8% of the male population in Saje-Ri was smoker, 33.6% of the residents consumed alcohol, 28.6% of resident used a salty diet. The rate of doing regular exercise was very low compared to the Wonju-Si (60.0%) which was 37.5%.

〈Table 12-3〉 Health behavior (%)

	Saje-Ri* (2007)	Wonju Si** (2004)
Current smoker	27.8(M)	53.5(M)
Current drinker	33.6	52.9
Intake salty diet	28.6	-
Regular exercises	37.5	60.0

* over 40 years M: male
** 2004. Wonju-Si Health Profiles

〈Table 12-4〉 ADL and IADL (%)

Level	ADL	IADL
independent	97.5	95.3
need help	2.5	0.3
Dependent totally	0.5	4.4

4) CHP Activities

Because of the increasing proportion of the elderly in the population and the vulnerability among groups, they are one of the main targets of the PHC through programs such as chronic disease management, health promotion activities (exercise, diet, smoking and alcohol control). Curative services have been decreased and preventive services have been increased.

〈Table 13〉 CHP activities (%)

Contents of activities	1986	2007
Curative services (primary care)	60.9	40.0
Health education	18.8	25.0 (health promotion activities; self-help group for chronic disease management, exercise class, diet class, smoking and alcohol control)
MCH* services & family planning	12.5	0.3
Mangement of TB	1.5	-
Environmental sanitation	1.3	-
Home visiting	0.5	27.0 (management of chronic disease for elderly)
Etc	4.5	7.7 (meeting, seminar, clerk work, education for village health work, patient referral)

* MCH: maternal and child health

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- Abstract -

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