A) General Situation

The start of the new year finds both Korean states confronting not dissimilar challenges, albeit in very different contexts and with different degrees of distress.

The first is the political change: Kim Dae-jung's accession next month as president in Seoul is matched by Kim Jong-II's confirmation in October 97 as leader of the ruling Korean Workers' Party in Pyongyang. Both leaders face the challenge of changing entrenched systems, and of cementing their personal authority in face of faltering economies.

The second is the economic pressures: In 98, South Korea may well experience, albeit from a vastly higher baseline, the negative growth seen in North Korea throughout the 1990s.

North Korea's economic problems, although they parallel those of the South, are of a vastly different order of magnitude, having much greater absolute and local consequence, yet having no significance for the wider world economy.

Remarkably, the near-famine and virtual collapse of the old, planned economy do not appear to have disturbed political stability in Pyongyang, nor prevented Kim Jong-II from steadily consolidating his position.

Moreover, the World Food Program would provide nearly 658,000 metric tons of food to 7.47 million North Korean, almost a third of the population. In launching the biggest appeal in his history - $378 million-, it wants to avert a heightened threat of famine this year. Assuming normal consumption levels, food stocks could run out as early as April or May.

For the authorities of Korea, food stocks will be empty in end of February.

Last year appealed for 141 million dollars for North Korea—that target 4.7 million Korean—got only 134 million.

At the beginning of February 98, no answer yet about this appeal 98 and the donors (USA, EU) are reluctant to answer without concrete proposals from the Korean government to improve the situation.

Before the new emergency operation begins, a nutritional assessment is planned. (March-April). This will be the baseline data by which subsequent collections will determine the effectiveness of food aid being received. Although terms are still being negotiated, there are good prospects that this study will have random sampling.

In fact, about shortage of food, nobody can tell exactly the situation.

In Pyongyang, the economic situation is getting worse: more and more shortage of water and electricity. The few trams and buses moving last month are stuck in the roads by lack of electricity.

For the people who were here last year at this period, the situation in worst this year.

The UN agencies—the NGO'S at a smaller level—are in the middle of a huge political game played by the help potential donors.

It is to fear, if a new Golf war will explode, all the attentions will be focus to it. The help for North Korea will be abandoned with the consequences what nobody can predict.

Mr Jong, director of FDRC left his place and started in Austria as diplomat. He has been replaced by two acting directors.
More NGO's are coming to start projects in North Korea: ACF, Oxfam, Merlin, MPDM,... They will be financed by ECHO.

Echo, already finances MDM, CESVI, CAD. For us, it is till end of March.

In fact, Echo finances all the NGO working in DPRK. Only MSF will have other funding for the North Hamgyon Province.

It will be interesting to see the game that Echo will play, with all of this power in his hands.

The representative of Echo will come back, in Pyongyang, on the 13th of February.

B) Programme:

1. Medical

1.1 MSF-B:
No news: the doctor in charge for the Province has been evacuated for medical reasons on the 18 of December 97. He will come back the 13 of February 98.

1.2 MSF-H: Made by Herbert Raaijmakers.

Medical report North Hwangae province

Period: January 1998

Drug distribution

No changes since the last report. The kit2's are still in the warehouse in Pyongyang and it looks they will stay there for quite some time. Lack of transportation is the main cause. We urgently need to find a solution for this problem otherwise it will really frustrate the program. There are still 25,000 blankets in the harbour in Nampho!

Training

This month I have started the training on the medicines in the kit2. The drugs I have discussed are hydralazine, furosemide, aminophylline, methyldopa, phenobarbital and promethazine. I also have trained the doctors on the principles of sterilisation and the use of the autoclave, which MSF has distributed to the hospital. Although the conditions in the classrooms were far from optimal (it was minus 5 degrees Celsius) the atmosphere was pleasant and cooperative. I have also distributed the new guidelines on the drugs of kit2 in the county hospitals. In the provincial hospital I had a meeting with the medical staff and a representative of the FDRC. The doctors asked me for more information about the drugs we are distributing. We decided to send them some English books about medicine. (The young doctors can read English). They also asked for different kind of drugs. My personal opinion is that as long as the drugs are on the essential drugs list we can discuss it and do something extra for the provincial hospitals. The next weeks I want to train the doctors in the correct use of antibiotics.

Epidemiology

This month I have analysed the morbidity forms and the weekly drugs consumption forms. The response I got was different from county to county. To me the figures of the following counties look somewhat reliable: Bongsan county, Suan county, Goksan county, Yontan county and Hwangju county. From Rinsan county we received some ridules figures e.g. they reported more than 110,000 cases of helmintic diseases.
After discussion with the health authorities we got some new figures but I am a bit sceptical about these new figures. The response of Sariwon city, Songrim city and Unpa county was also disappointing. It's not so difficult to obtain figures but to obtain some realistic data is a another cup of tea. We not only have to convince the national authorities but also the authorities of each county about the importance of realistic data. Personally I think it will take a long time before we will receive realistic data on which we can base our program. For who is interested I will add some figures to this report.

General discussion

- **Extension of the North Hwangae province with 4 more counties.**
  Personally I believe it's possible to extend the programme in the North Hwangae province with the 4 counties of the IFRC with the same staff. I have done already a lot off training in the province so my successor will have some time to take the extra counties. I also believe that it's more effective to take the extra counties and than ask for extra people than vice versa.

- Recently we received an article which was published in “The mission” of MSF-F. Unfortunately the article was anonymous so I can’t reply the author personally. I can only hope that he will take the effort to read the reports we write about our job but I am not so optimistic about that. In the article the author mentioned that we aren’t able to touch the patients. To correct that misunderstanding I want to explain what we can do and what we can’t do. The last 4 months I have visits hospitals and ri-clinics almost every day. During those visits we look at the patients, we talk with them, we examine them if necessary, we look at the medical charts and we discuss the treatment with the doctors. We also go to the operation rooms and see operations. Of course we go to the pharmacies and the warehouses to look at the drugs.

  As I mentioned in my earlier reports we have an reasonable freedom to visit the health structures at randomly. Every week the situation improves and the atmosphere becomes more and more open. We are not allowed to obtain objective data about the health situation of the people. The data we have received so far are not reliable. Of course you can question our being here and if we should expanded our program. But that discussion should be held openly and be based on facts not by an anonymous person who doesn’t have a clue what he is talking about.

Greetings

Herbert
### Morbidity Form

**PERIOD:** NOVEMBER 1997  
**POPULATION:** 1,379,585

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Medical report KANGWON Province January 1998

After getting to know the MSF team members, local and hospital staff, working and living conditions I have now got used to working in DPRK. We, the nutritionist and I, are the MSF-F team in DPRK.

Training

All counties have been trained on the use of the drugs of Basic Kit 1 and the antibiotics of the Supp Kit. The doctors have a good understanding of the drugs used and accept and appreciate the new drugs previously unknown to them e.g. cotrimoxazol, paracetamol and benzyl benzoate. During the training sessions we have meaningful discussions on treatment and diagnosis of different diseases. It is very difficult to get any real information concerning the treatment, diagnosis and follow up of tuberculosis. The doctors deny having seen any cases of STD's (gonorrhoea, syphilis, chlamydia or HIV) but are interested in diagnosis and treatment.

The medical knowledge varies, with the older doctors who have been working before the "floods" having a good clinical and theoretical knowledge but the newly graduated younger doctors have never had the possibility to use non-traditional medicines or modern diagnostic equipment. All doctors are very motivated to discuss and learn about new medicines and treatments. We have also started with training on sterility and hygiene especially in the operation theater for surgeons and OP staff. The surgical skills are good but due to lack of material, fuel and electricity there is much to improve in the surgical departments. I have no access to figures on mortality or post-op infections but I suspect an unnecessary high number of cases. The need for anaesthetics is big, now only spinal or local anaesthesia is used. The lack of material and sterility is the reason why I will not introduce Ketamine until the basic sterility needs are fulfilled.
I continue to inform them of the usefulness of morbidity and drug consumption charts. It is very difficult to get reliable figures. I have the feeling that many numbers are adjusted to satisfy MSF or to try to get more drugs for the next distribution because of a high consumption.

We have received and distributed the guidelines in Korean on the Supp Kit drugs to each hospital. All clinics should have the Basic Kit guidelines in Korean.

**Distribution**

The distribution of SUPP KIT and KIT 3 is completed. From the distribution of Basic Kit 1 160 kits were left over to be distributed by MSF in the next phase. These kits have been distributed on order from the provincial health director evenly among the counties. Some of the kits have gone to “hospitals” I have decided NOT to support because of low catchment area or location close to the county hospital. These hospitals have material for surgery but the number of operations is not enough to justify the upgrading from “clinic” to “surgical hospital”. The distribution of kit 3 and Supp Kits have also been adjusted to favour the hospitals in Wonsan city (the capital of Kangwon province) or hospitals not supported by MSF- see above. I have had long discussions with the authorities concerning the changes in distribution without my knowledge. I hope there will be no more problems in the future.

The blankets and sheets intended for the hospitals to be used during the cold winter are still in the warehouse. The lack of fuel and transportation is obvious in DPRK which also affects MSF. The KIT 2 have not been distributed because of the same reason. We are pushing FDRC to provide transportation for our supplies to the provinces. These delays in distribution is something to take notice of for the coming distributions, everything takes a long time in DPRK. The first distribution of F-100 milk has been done without any problems and the nutritionist is now starting a second distribution.

**Access**

Among all NGO's and UN organisations working in DPRK it seems MSF has one of the best access to the field. I can freely visit clinics of my choice. For hospitals I need a schedule one week in advance. Due to the mountains terrain and the large area of Kangwon province we have difficulties reaching the most remote counties. We have repeatedly asked for permission to stay overnight in the field but have so far been denied this.

I have visited the Medical University in Wonsan. They have some modern equipment (microscopes) but lack examination material, laboratory equipment etceteras. There is also a great need for medical books.

We have so far been denied access to the Tuberculosis Clinics/hospitals.

**Future**

Hopefully distribute the blankets and KIT 2 ASAP.
Collect drug consumption and morbidity charts for the last months from all hospitals and clinics.
We have started assessment of the non-drug medical/logistical needs for the Hospitals.
We will discuss with the teams from the other provinces to make the same order for all teams. There is great need for soap, basins water sterilisation for infusions etceteras.
Continue training on the Supp kit drugs for the hospitals.
Try to get access to TB-wards, center for mentally retarded persons, psychiatric wards as the orphanage for elder children.
The mission

MSF is working in three provinces with two expats covering each province of 1-2 million people, about 14 hospitals and 275 clinics. The time is shared between drug/milk monitoring and training. With long distances to travel it is difficult to visit more than one county each day. This means it takes about three weeks to complete each training session. It is important to use the time efficiently and to train on meaningful topics.

The hospitals have a lack of all sorts of material, drugs and equipment and has been without these for many years, possibly from the beginning of the '90s. Without daily work with equipment and drugs doctors lose their skills, and the patients no longer come to the hospitals because there is no cure to give. This means that there are many basic routines/medical handling that need refreshing training. The medical problems will not be solved by providing more and specialised drugs, but rather with basic training on hygiene, sterility, dressing, and good training on the drugs already provided. To manage this in an efficient way there must be co-ordination. The MSF medical team in DPRK has been reduced during long time at different intervals due to illness and early ending of contract. There has been very little medical co-ordination or medical planning for the future. I feel that continuing in the same manner is not meaningful, there must be some long-term planning. I hope we soon will get a medical co-ordinator with experience of this kind of unusual MSF-mission.

The monitoring of the drugs is time taking, but goes a lot easier now than in the beginning as trust has been built up between the hospitals and MSF. The drugs reach the hospitals and clinics with very few boxes disappearing. I have no suspicion of organised "rerouting" of drugs to the army, other provinces or for sale. I have the feeling most of the non-matching of stock cards/drug consumption is because drugs are stored in the hospital to be used when MSF has left and the hospitals have to rely on government distribution. The biggest problem in drug distribution is the delay from the suppliers in Europe together with transportation problems in DPRK.

Rickard Ljung
Medical Doctor in Kangwon Province
2 February 1998

2. Nutrition

2.1 MSF-B:
No news: the nurse/nutritionist in charge for the Province has been evacuated for medical raisons on the 18 of December 97. She will come back the 2d of February 98.
Third nutrition report North Hwangesa, by Inge Verdonk

Activities in December/ January
All 12 county hospitals (where the TFC's are in the paediatric) were visited once or twice. In this period all hospitals who needed it received a second tonne of milk.

I discussed this period mainly the following topics:
• The preparation and drinking of HEM.
• The use of the vitamins and the iron folic tablets we distributed.
• The use of chlorine.
• Breast feeding and weaning practices.
Further more the first nutrition co-ordination meetings were held.

Prevalence of malnutrition
It is still difficult to make estimates of the extent of malnutrition among the population. The admission rates (see attached 'tabinge') show more how much fuel is available in the hospital to heat-up rooms and how much human energy is put into treating outpatients, than how many malnourished children are present in the county. In some hospitals the admission rate is always highest in between my visits, which makes me doubt a few of the figures.

Preparation and distribution of HEM
In most hospitals the preparation and distribution of HEM is well done. In two TFC's the milk was wrongly prepared, in the other 10 it was done well. They all had their own system to register how much each child should get, except in one hospital this went well. In some hospitals they did not give a second round for children in phase 2 who were still hungry.

The main problems were that in all hospitals that the mother keep the spoon which is not cleaned in between meals. In some hospitals a few mothers used bottles (not cleaned in between feeds), the hospital does not provide bib's (in NL slab), if the hospital has mattresses the mothers have problems to keep the cups with milk from falling. I am surprised that it does not smell worse in the wards.

Vitamins an Anaemia
In the medicine kits we distributed Vitamin A, C, Folic acid and Ferrous sulphate. A hand-out has been made on its use.

Vitamin A: In most hospital they see regularly (1-2 times a month) cases of xerophthalmia (lesions on the cornea) among the children. However I doubt if they really identify this correctly and if they do not also include conjunctivis. In one hospital they also saw about 10 pregnant women with cornea lesions (population 20 000).

There was some confusion on the recommendations for the use of Vitamin A. First we prescribed 3 pills (200 000 IU each) for all children above 1, according to UNICEF guidelines. But after discussions we will probably revise this to 1 pill for all and only 3 pills if symptoms of vitamin A deficiency.

Anaemia: In some hospitals they say most malnourished children have anaemia, in others they say most malnourished children are not anaemic. Several doctors estimated anaemia among pregnant women more consistently at about 20%. Since most
laboratories are not functioning, anaemia is diagnosed by looking under they eyelid, which might explain differences among doctors. It might also be truth that their is a real difference (e.g. depending on iron in drinking water, hook worms, etc.). The prevalence of anaemia among pregnant women is surprisingly low considering the diet (mainly rice and fermented cabbage).

Hygiene

Hygiene is a problem in the hospitals, there are only simple latrines outside the hospitals, there is no running water in the hospitals. The patients cannot be washed in the hospital. If a child has diarrhoea it will be cleaned with a damp cloth. We are now distributing chlorine, of which we have enough in stock. In the next phase we will also distribute soap and washing basins.

Breast feeding and weaning

I have written a two page paper on the subject and send it to Saskia.

Nutrition co-ordination meetings

Up to now there has been little co-ordination among the agencies on the technical issues of nutrition. We therefore initiated a first meeting at 17 January in which the UN agencies and NGO's participated who are involved in nutrition programmes. We decided to have future meetings to discuss the following topics: Breast feeding and infant feeding, need for training; Vitamin A, need for nation wide programme; programmes for prevention of malnutrition; practical issues and training material for running a TFC. The meetings have been very fruitful in reflecting our own programmes and joint efforts.
In Songrim only the total number of oedema is known, for this report I divided them over the two age groups.

In Hwangyu and Rinsan the oedema among >5 is not known.

2.3 MSF-F: made by Fiona Laird.

Nutrition / Nursing report Kangwon Province January 1998

The feeding centres are generally showing less children than in November, and they are following the feeding protocols more effectively. There has therefore been more time to focus on more nursing/medical issues.

Feeding centres.

Data is now available for November, and for most of December (attached). There were less children admitted for December, and on the whole, they looked less severely malnourished, but there still remains county to county variation in degree of problems seen. It is increasingly apparent that many children fall into the category of moderate malnutrition when using weight for height, have fullish faces, but have MUACs that would indicate severe malnutrition, so the picture is confusing. At present it is impossible to interpret anything meaningful from the data, especially in one or two counties where the numbers look very dubious. However, the staff in the paediatric departments and the mothers resident in the hospitals all report that the malnutrition situation is vastly improved thanks to the F-100. Paediatricians reported that the...
previous year there had been several deaths from malnutrition witnessed in the hospitals, and therefore probably more unwitnessed at home. Since using F-100 there have been very few deaths within the province, and it has been heartening to witness some of the children who were 60% weight for height, get rounder. The mothers report that within their villages the situation has now improved. My impression is that close to the county hospital, malnutrition has been treated well, but I am still concerned that children living further away are not being properly reached. There remains distinct reluctance to start feeding from the RI-hospitals, and a distinct lack of feedback about how else these children can be accessed.

The standard of feeding seems to be improving, as fewer mistakes are obvious, and weight gain is usually reasonable. There is definitely a correlation between consistent visiting and maintenance of standards, as the counties that had not been visited for long period became ‘creative’ in their interpretation of milk use. Most often this was because they fear that the supply will not last. In fact, nearly all counties have used almost all of the milk distributed in the first instance (total 28 tonnes distributed), and so the remainder of the milk acquired from CAD is in the process of being distributed (12 tonnes), in the interim, and then UNICEF milk will be distributed.

Communication with medical staff is becoming easier as they begin to know us, and so information is easier to acquire. Increasingly I talk with the mothers in only the presence of my translator in an attempt to get a more accurate view of the situation in the homes, but a clear picture has not yet been established.

Following the controversial interagency nutrition meeting, arranged by Inge MSF-H, there have been several focal meetings, with several others planned. A meeting on vitamin A will take place next week. The potential for a nationwide distribution of vitamin A will be discussed more fully. At the moment, the paediatric staff give variable reports about the incidence of vitamin A deficiency, between 2-20 cases a month, with only one hospital denying any problems. Issues surrounding breast feeding and weaning are also being explored further. From the current information, it appears that the mothers with breast feeding difficulties are taught by the doctors how to make rice porridge, or use goat milk. Many of the clinics have a midwife, but when asked about who gives advice to mothers with breast feeding difficulties, the doctor is always mentioned. Support for these mothers seems to be lacking in the community as it is quite common to see malnourished twins in the hospitals. Rice porridge is also used extensively for weaning, but there are comments that protein such as fish and meat is not easily available. I am told that some dedicated doctors go fishing in an attempt to find fish for the children.

Nursing / Medical

Training has been started on the supplementary kit. Firstly, training was given to theatre and surgical staff on the use of the autoclaves. Sterility was discussed, and the method of putting on sterile gloves was demonstrated. The staff appear to have an understanding on the concept of sterility, but it would seem that they have not had the resources to practice it effectively for several years, therefore this update is very necessary. They greet the arrival of the supplementary kit with great enthusiasm, and appear to listen carefully to the training. When we leave the room, they often have animated discussions between themselves about the new equipment.

Training has also been given to the pharmacists on the safe handling of chlorine (70%).

Fiona Laird 2/2/98
Kangwon Province. Number of children treated in each TFC for NOVEMBER

<table>
<thead>
<tr>
<th>County</th>
<th>Children &lt; 5 years</th>
<th>Children &gt; 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>W/H&lt;70%</td>
<td>Oedema</td>
</tr>
<tr>
<td>MUAC&lt;110</td>
<td>MUAC&lt;110</td>
<td></td>
</tr>
<tr>
<td>Anbyon</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Chonnae</td>
<td>17</td>
<td>41</td>
</tr>
<tr>
<td>Hoiyang</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Kosan</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Kosong</td>
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<td>0</td>
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<tr>
<td>Munchon</td>
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<td>45</td>
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<tr>
<td>Pangyo</td>
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<td>8</td>
</tr>
<tr>
<td>Popdong</td>
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</tr>
<tr>
<td>Sepo</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>3</td>
</tr>
<tr>
<td>Won. City</td>
<td>19</td>
<td>4</td>
</tr>
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<td>Prov. Paed</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Wonsan Provincial paediatric hospital: died, 12 year old with oedema and pneumonia, 8 year old with meningitis.
Hoiyang: died, ages 6, 9, 12 and 13. Two had oedema and one complicated with renal failure.
Kosan: the figures are dubious, as they were different last week.
Sepo and Hoiyang were not accessible for visiting, but reportedly had ‘campaigns’ to feed as many children as possible before winter. Sepo numbers do not have
Sepo did not have detailed data, but have always appeared to be one of the most severely affected areas, followed by Hoiyang.

4 died, all >5yrs dubious data
data not available data (Nov+Dec)/2
2 died
January was my first full month here. After having arrived on the 20th of December. The logistic handover was rather quick because Pete had to finish the accounts before he left. Because there was no financial administrator till the end of January it became apparent that the practical finances had to be done myself as well.

**Ordering.**

The project is in-between two budget periods of the southern projects and about to start-up a new program in the north so planning had to be done and orders had to be made for the continuation of the present program and the start of the new program. Small adaptations were made to the kits (smaller gloves than previous, and the replacement of NaDCC by HTH).

Two shipments arrived:

- Five containers with the medical kit number 2.
- Five containers with sheets and blankets.

### Table: Medical Supplies

<table>
<thead>
<tr>
<th>County</th>
<th>Children &lt; 5 years</th>
<th>Children &gt; 5 years</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>W/H&lt;70 Oede ma 0%</td>
<td>W/H&gt;7 Oede ma 0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MUAC&lt;110</td>
<td>MUAC&lt;10</td>
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<tr>
<td>Hoiyang</td>
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</tr>
<tr>
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<tr>
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<td>12</td>
<td>3</td>
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<td>8</td>
<td>108</td>
</tr>
<tr>
<td>Prov.Paede</td>
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<td></td>
<td>703</td>
</tr>
</tbody>
</table>

**Logistic report North Korea, January 1998.**
Transportation.

MSF cars.

Pete (previous log/admi) had secured a large stock of diesel fuel which I could receive but which was not tested. To make sure that the program could go on running during winter it was necessary to do some test on this stock.

Result:
- Local winter diesel stock. Is fine after the first lot which came from the bottom of the tank where the tap is (lots of paraffin in bottom fraction) rest is safe till -22 (the lowest temperature reached in the freezer).
- Emergency stock bought in China. Lots of paraffin, dirty and solidly frozen at -15. When we use this stuff we first have to filter it. At the moment just kept in reserve.

Anyway the lowest recorded temperature here was -17.

There was a back-lock in training of the drivers and dissatisfaction with the driving style of the drivers. Quite some time and energy has been put in this and things changed for the better. A basic maintenance and registration system for the cars was set-up.

Transportation of MSF goods.

Goods are not transported by MSF nor under MSF control. Transport from the harbour to the central Pyongyang warehouse and from there on to the provinces is done on instructions of the FDRC. Both stretches take a long time. It is hard to find out what the transport constrains are because the only reason given is the weather leading to bad road conditions. Indeed the weather was pretty bad at times but never for a prolonged period and the stretch from the harbour to Pyongyang was usually clean.

On the ship, in the harbour and on the road the material has been frozen, no visual damage to the products has been witnessed until now. Packaging has suffered however of rain water entering the containers and condensation of water inside the containers.

The trucks I saw which were used by the distribution of medical goods were in pretty poor condition and not really suitable for the job. Common practise is to have passengers on top of the load which does no good to the load either.

General transport.

Transport in general is problem in this country. All trucks are old and worn out. Fuel is relatively expensive. There is a heavy demand on trucks because some of the railroads have stopped running. The allocation of trucking capacity is a political matter (one day the streets were filled with trucks with scrap metal with political slogans on top declaring that metal was the best gift to the workers, these trucks just drove up and down the main streets). The best trucks are army trucks which are not used for civilian purposes. Still trucks are used for prestige projects.

Distribution.

Distribution has been limited to milk powder. Medical kits had to be sampled and tested by the authorities and are now free for distribution. The sheets and blankets were held up because of an internal power struggle inside the FDRC. They were claimed by the ministry of commerce because the were not medical. The medical faction won so they are now expected to be free for distribution soon.

Field visits.

Three field trips were made in order to get aquatinted to the work of the project. One trip was aborted halfway because of heavy snow.

Conclusions until now on the visited health structures:
Many needs.
Very cold, lack of fuel, central heating dysfunctional for already many years. Wood and coal stoves are used of bad quality resulting in smoky rooms. Large but empty buildings of poorly build quality. Much broken glass. No electricity. Electric system dysfunctional for already many years. Water system primitive and broken down. Visits are orchestrated, real situation is not shown. Photography of patients and so called “shameful situations” not allowed.

General idea of the visited area:

Nearly total use of all arable land, even on steep slopes.
Nearly al wood and scrub is gone (in the stove).
Rural population has no real work during winter and is just hanging around or is used to sweep streets and bring tiny buckets of poor quality compost to the fields.

Housing.

MSF-Pyongyang extended to a fourth apartment in few of the enlargement of the project and HQ staff. Office space was reallocated and the electric system was made more secure and functional.

Communication.

Communication to Europe is by phone, fax and e-mail all at a price of 5$ a minute. Even failed attempts are charged for and this happens a lot. This all results in a very high phone bill. Better registration is done now to control matters but ways have to be found to really reduce the costs.

Electricity.

Electric power supply was good at the end of the year and beginning of the new year but deteriorated. Power cuts are more regular specially during the day. Power cuts during the evening usually last about 10 minutes. Elsewhere in town the situation is worse. The largest part of the public transport is by trolley and tram and the power and cable cuts cause enormous disturbances.
The grit voltage fluctuates between 184 and 228 volt and 48 and 53 Hz which is no problem for the regulators and equipment. Some regulators were found to be faulty (giving a dangerously high out-put voltage).

Lieuwe Montsma.
Log-cor.

4. FUTUR.

4.1. Programmes.

With the arrival of an expat administrator, the function logistique/administration/finances has been shared between 2 expats. It means the logistician can go often on the field to evaluate the needs in small rehabilitation and logistic.
We don’t speak about rehabilitation of the huge provincial hospitals, but at the ri level : clinics and hospitals, in a same county. It can be the first step near the ‘district operational’.

We distributed all the material, except the kits n°2 who arrived only end of December. We can, now to reorient our strategy and to go deeper, as asked by the last interdesk meeting .On the field, where the teams are working 5 days a week, the contacts are already made and the MSF doctors and nurses are not anymore seen as strange white
people. In some places, in the counties, the last foreigners they saw were American soldiers who came to kill them. It was in 1952...

We can speak with the doctors, exchange with them.
We have access to the mothers in the maternity and we can speak with them, through the translator but without FDRC and provincial responsible around.

For the moment we can choose on Friday which counties we will visit the week after.
For the clinics, we decide the same day, we have no to advice before.

For the moment, all the contacts and discussion about the project we have, are throughout FDRC where there is no medical people. We have to find a way to have more contacts with people from Ministry of Health, at the high level but also at the low level.

A first step has been made when the expatriate nutritionists (MSF-Unicef-CAD-MDM) organised a meeting about the breast feeding and a doctor of the maternity of Pyongyang came at this meeting.
It is a very small step, but it is one.

It is clear the things changed from the beginning of the MSF mission on Korea. We have, already, more contacts on the field and it will be improve more and more.

In Korea, all goes slowly, the things can change step by step, but not in one day or in one week.

During the previous months, we are the only organisation to go on the filed for monitoring the distribution of the drugs. Now, with the others NGO coming in (MDD, CSV), WHO WILL WORK AS US on the filed, who will have the same approach, it will be easier to propose the same strategy to the authorities.

We will start to work in the North Hamyong Province around the 9 of February. Two logisticians will go to install all before the coming of the medical team and the full charter.