TO MSF Belgique: William Claus and Jean Marc Biquet
TO TRANSMIT TO MSF-France - Pierre Salignon-, To MSF-Holland -
Pim de Graef.
FROM: Marie Rose Pecchio.
Date: 28 of February 98.

MSF DPRK

Monthly report
FROM 01/02/98 TILL 28/02/98

A) General Situation

The food remains the most problem for this month in DPRK.
Numerous monitoring reports indicate that food is getting scarce in some areas of the country.
Government and local officials indicate that food may no longer be available in some place by end of
February. Rations have come down to below 400g per person per days, in some areas to as low as 100.
According to WFP/FAO harvest assessment calculations, indigenous and international food supply will
be adequate until at least the end of March. But if the Government says that it has run out of food, who
will happen?
WFP has no donors at this stage for the appeal, which has been launched in January. One problem is the
Letter of Understanding between WFP and the DPRK Gvt has not yet been signed, and donors are
reluctant to commit large amounts of aid without a clear understanding of the terms and conditions
regarding access, staffing, communications and the like.

‘L’ECHO’, as they call it here, came back on the 21 of February. They have, at least, 12 millions of
ECU for North Korea. This money can, not have to, be spent if there are needs and if the Gvt shows a
wish to let more people coming in the country.
It seems that they will agree to fund MSF for the 3 provinces of the South till the end of our MoU.

After the fightings of January with UNICEF, the stillness is come back. They agreed, again, to give us
the HEM for the 3 provinces of the South, on a monthly basis, from March 98 till the end of July.
For the North, it will be possible from June 98.
All the fightings began in January because MSF organised a technical nutritional meeting, with the
nutritionists working on the field (MDM, CAD, MSF) and the nutritionist of UNICEF. The purpose of
was to exchange points of view about the work on the field.
The problem was that we did not ask the authorisation to Unicef (the Special Representative) before.
In the same time, an other health sub-group has been implemented with the purpose to put clearly on
paper, the needs and the priorities in the health sector.
The top of the ‘crisis’ has been reached when Unicef called the NGOs at a meeting with FDRC to tell
us that Unicef will not be anymore a supplier of HEM. If we are not able to have our own Hem, Unicef
can take in charge our activities!!!!
FDRC asked us our intentions for the future about this HEM... Very embarrassing.
At the next health meeting, it was a big fight between the Ngos and Unicef about the FDRC’s meeting.
I met the Special Representative of Unicef, some days after, to stop all these fightings. We are not in
DPRK to fight but to try to implement health and nutrition projects.

ACF signed his MoU and will begin in the North Hamyong Province, in the same counties of MSF,
some supplementary feedings centres. It will be complementary at our project.
Oxfam will begin a sanitation project in Pyongyang.
Some others NGOs came to make assessments about health projects.
A NGO, called HOPE, is arrived with 10 millions of USD for 2 years. It will provide drugs and medical equipment for Pyongyang. Nobody knew, but the first shipment will arrive on the 2d of March. No monitoring and no expatriate for the supervision.
An other one, called ACT INTERNATIONAL, has imported raw materials in December 97, for making drugs in the North Korean factories. Aspirine, chloropenicol, tetracycline, procaine will be produced. They will continue for 2 years, at least. These drugs will be given to the MoPH. To where? No answer yet.
Some time I have the impression to be in a big souk where all is permitted, where you can arrive with what you want.

A delegation of WHO came to visit the country. The results are:

WHO will work at the central level. They will implement a system for collecting the data. In DPRK, the system is still the same as ours in 1970.
They have no plans about the drugs in DPRK for the future. They don’t want to import raw material; controls of quality are too difficult to do.
They will work in 7 counties on a TB project.
They made an assessment about malaria: there is malaria in the country, but only in the border counties where no foreigners are allowed to go. May be in the next budgets we can provide some mosquito net for the hospitals. Incredible but true.
Talks quite disappointing for us.

Last Sunday we had a team meeting with the new and old team about our projects in DPRK, what has been done and what can be the future.

Minutes team meeting about:
1. project progress
2. ideas for the future

Pyongyang, 22-2-1998

Present: Marie-Rose, Lieneke, Geneviève, Dominique, Brigitte, Herbert, Inge, Fiona, Ricard, Guillaume, An, Gunther, Sjors, Edwige and Corien (minutes)

After opening by Marie Rose, we decided to split up the group in two, because of its big size.
Both groups had md’s, nutritionists, ‘old’ and ‘new’ expats, and discussed among themselves, whereas two presentations were held and conclusions were combined as followed:

Medical:
Project progress
Drug distribution as performed until now satisfactory. The drugs are on the right place, with only small expections. Most of the doctors prescribe them in the right way. The training how to use them has been picked up adequate. The impression is that the doctors have enough basic knowledge to use them in an appropriate way.
The patients numbers visiting the hospitals are improving (as is the weather), we therefore are also able to monitor the diseases in our provinces in a better way.

Relations/contact with authorities is good, it is clear they trust us more and more.
It is felt as very positive to be present in 4 provinces to work on a broad scale. But we worry about the Korean medical system for that it is not sustainable itself, and MSF will never be able to make it sustainable as well...
Future ideas
To be able to make decisions on which we will focus on the future, it is generally felt that we first need clarity about the project objectives and aims. The drug distribution in the 4 provinces is good/necessary, by which we get a general idea about the morbidity (maybe enough?), but monthly morbidity-data gathered never will be reliable when only with one md per province. For that we better can concentrate to take care of one county per province, and gather better data by continuous presence (but can we extrapolate that to other parts of the country?). So are we giving priority to large scale/less reliable system, or small scale/more reliable information. Maybe we can do both?

Nutritional:
Project progress
When the project started, there was an emergency situation, and the choose for TFC’s is considered to be the right one. Over all however, not many malnourished children were admitted to the TFC’s. Reasons probably the same as in other parts of the world: mothers also have other children, cold on the wards etc. Lack of cooperation with the authorities or medical personal seems not to be the case.

Future ideas
Now the emergency phase is over we should concentrate on moderate malnourished children. It is felt that we should look for another programme, which could reach more children as well. That could be the Supplementary Feeding Centre’s at the Ri-clinics, this would be more sustainable as well. Attention should also be given to implement a better referral system to the hospitals.
Furthermore we should try to get access to orphanages. Maybe we can delegate part of training (by teaching trainers).
Also among the nutritionists a lack of project objectives and goals is felt, both for evaluating what has been achieved until now, as for setting priorities for the next phase.

Logistics
The main problem is the delay in drugdistribution because of late arrival of drugs from Europe. IDA cannot handle our big orders, and shipment to Korea takes time. It is proposed to unite the drugorders of the several NGO’s present in Pyongyang. Purchasing drugs in Asia did not get general support.

MSF-International
It is considered very positive that the French and Dutch desk will visit us next month.
The system of province/section is felt to be stiff, for general cooperation it could be better if expats are interchanged (f.e. both belgium and dutch nutritionist/md expats in a province). This could also be done on temporarily base?

Some members of the team are leaving:

- Inge Verdonck: nutritionist, MSF-H. She will leave on the 28 of February. She goes home in Bhutan. She will do her debriefing by phone with Amsterdam.
- Herbert Raaijmakers: doctor, MSF-H. He will stay in the country and will work with UNICEF.
  His MSF’s contract finished on the 28 of February.
- Fiona Laird: nurse, MSF-F. She will leave on the 28 of February.
All first mission....

The team of North Hamyong Province left Pyongyang on the 23 of February for Chongjin. All of them worked before with MSF.
We are expecting the first plane around the 15th of March, inshallah. In Europe, the kits are getting scarce.....
The next shipments will arrive by boat.

We are expecting the arrival of Pierre Salignon, desk MSF-F and Philippe Biberson, President of the board of MSF-F. May be Pim de Graef will join them. Inshallah.

B) Programme:

1. Medical

1.1 MSF-B : by Dominique Lafontaine.

Monthly medical report for the South Pyongan Province - February 1998

Distribution

1. Drugs distribution

After two months of absence we were very anxious about the running of the distribution program in our province. Just before our departure the provincial authorities and all the county health directors had received the distribution plan for the next months. Due to the bad weather and the lack of fuel and trucks, it was proposed to distribute the total amount of kits directly to the county warehouses. The county Health Director might have the responsibility of the stock and to distribute monthly the kits as our distribution plan. This proposition haven’t been accepted by the provincial authorities mainly for administrative reasons. It was then decided to divide the distribution in two parts:

- first, three months together with a retroactive effect (thus, October, November and December together). This decision was taken as we were not sure to stay after February and as we thought that it was better that the stocks were done at the lowest level as possible, so, the health structures itself. This distribution was done at the beginning of December and was monitored by ourself at the beginning. All the boxes were checked in the county warehouse and a specific mark was drawn on it. We left after but our instructions were clear for the next step and it seems that all happened correctly.

- second, two months together (January and February) might be distributed during January. The provincial authorities have managed themselves this distribution according to our plan. As they have received the distribution plan previously, it was not a problem for them to manage it correctly. We were not present during this phase and the monitoring was not done, but later, during our field visits, we haven’t notice any misinterpretation of our distribution plan.

Actually all the dispensary kits, supplementary kits, kits 1 and kits 3 have been distributed. The kits 2 that we have received very lately (end of December) will be distributed during the amendment phase (March to May). The first shipment of kit 1 will arrive at the beginning of March, so the distribution of it will begin in April.
2. Blankets distribution

It was a bad surprise when we have discovered the blankets. The local reaction was also very strong. It's not normal to give them refugee blankets as hospital blankets! The winter is particularly hard and most of the health structures are badly heated. So, it was not a luxurious gift to provide them with good blankets. The message given to the logisticians was clear and our dissatisfaction is big. These refugee blankets will be distributed during the spring ...

Monitoring

During our field visits, we can now go deeper when we collect informations from our guests. There are still a lot of touchy points, but step by step we begin to understand more and more on the system prevailing in this country. We will never reach a complete understanding but some of our problems can be put in a better perspective than before. It is the case with the monitoring of the drugs distribution. Actually, we have the clear impression that a lot of drugs are withdrawn from our attention and keep in a special stock. That means that not all the drugs are delivered to the population in the present time. We think and I'm personally persuaded that the intention is not to keep away these drugs for an inavouable purpose but to use them later after our departure from the country. MSF will leave one day the country without any replacement. North Korea is always in a war-game and the general mentality is always to keep in stock the essential stuff as the food and the drugs.

The given explanation doesn’t satisfy us, mainly because we are not sure that the population needs are fullfilled by our program. Nevertheless, when we push the different responsibles we are always (until now) able to see the hidden stock. That means clearly that the distributed drugs are at the right place but not fully use until now. The unanswered question is to know if they stock because the population consumption is lower than expected or because there is a real willing to do it even if the population needs the drugs. Our attitude will be totally different according to the answer.

We continue to collect the consumption and the morbidity forms during our regular visits to the health centers. The existence of the hidden stock means that the reliability of all consumption data are dubious. As in their mind there is a link between these consumption data and the morbidity data, it’s clear that the morbidity figures are also totally wrong. To have a better understanding of the local morbidity and of the drugs consumption, we plan to analyse on a deeper way the prescriptions made by the korean doctors. These are a wealth source of information as they give the diagnosis, the chosen drugs, the number of prescriptions each day (so, roughly, the number of consultations). They are kept in reserve for putative control during at least three years. So, if we have access to the six last month, it will be possible to demonstrate the impact of our program.

Medical coordination

Relation with other NGO’s and UN organisms

- Some new NGO’s arrive in DPRK.
- Capanamour, a german one, is working now for drugs distribution in the South Hwangae province in collaboration with CESVI.
- OXFAM-UK are in the process to sign a MOU with the FDRC for a sanitation program. It's almost sure that they will work in Pyongyang City, but they hope also to work at least in one of the peripheral provinces. South Pyongyang will be a good choice for them and for us.
- AICF will implement a supplementary feeding program in the North Hamgyong province. The centers will be situated near our therapeutic feeding centers.

- The technical health meetings are in progress. During the month of march, at least five meetings will be hold on a weekly basis to identify the major needs for 1998 and 1999.

  23 february - Baseline data
  02 march - Drug distribution system
  09 march - Childhood problems in Children's Centres
  16 march - Training practices
  23 march - Preventative and curative methods
  30 march - Interagency/Donor co-ordination

The baseline data meeting identified the need to coordinate the morbidity forms used on the field. For example, MSF, MDM and the Red Cross Federation (IFRC) are actualy or plane to use different kinds of forms, which will complicate the analysis of the data. A consensus must be reach to avoid this problem. This consensual morbidity form will be linked to other forms devoided to the food and sanitation aspects. Each NGO's will use on the field this new general form. Everybody agreed on this project. We have annexed a morbidity and a Health Facilities Assessment forms (see annexes)

- The DPRK asks to the WHO to train the korean medical doctors on an information system for the communicable diseases. The informations will be gathered by the peripherical health structures, sended to the MoPH and latter analysed following WHO criteria. The data will be given to teh WHO, which promises to share it with the other organisms working on the field.

Dominique Lafontaine

1.2 MSF-H : by Herbert Raaijmakers.
It is not a monthly report by his final report.

Medical report North Hwangae

Period: September 1997/ February 1998

Situation at arrival
When I arrived in the DPRK, 4 MSF'ers had worked for 2 months in this project. They had already met the authorities in the North Hwangae province. Some training had been given and the first distribution of drugs had just taken place.

The first weeks I had several meetings with the health authorities of the province and the counties. I explained to them what kind of help they could expect from us and what we expected from them. Furthermore we visited the hospitals and the clinics.

During those visits we interviewed the doctors and the county directors. My first impression was that the situation was worse than I expected it to be. There was a lack of almost everything and the hospitals looked abandoned. The little equipment they had was more than thirty years old and not functioning. There were no laboratories, almost none surgical equipment and only Korean medicine. There were very few patients hospitalised and most hospitals looked deserted. The situation in the ri-clinics was better. The clinics were clean and the doctors kept a medical record of each person in their ri. Although the doctors had to work in very difficult conditions they still looked motivated to me. During our visits the atmosphere in general was pleasant but we also met a lot of suspicion. Understandable if you realise that they hadn't seen foreigners for more than fifty years.

**Activities during my stay in the DPRK**

- **Supervision of the drug distribution.**
  When I arrived the first distribution had taken place. The dispensary kits, waterfilters and scales were distributed to the hospitals and ri-clinics. Because it was our introduction time we agreed that the Koreans decided the program. In the clinics we visited everything was there what we expected to be. The second distribution took place in December. Because of the transportation problems we decided to distribute the remaining drugs to the clinics at once. To control if the distribution was done properly we insist on an free choice of visiting the clinic. After some discussion they agreed that we were able to visit the clinics random. But in reality it is still a fight to have free access to the clinics. In general the distribution was done well. At some places some boxes were missing and one county didn't receive medicines at all. After some questioning this county also received their drugs. At this moment the distribution of the kit2 is taken place.

- **Training doctors**
  After our introduction visits. I started training the doctors on the kit1 drugs. In every county I gave the training to one doctor of each clinic. I also explained the morbidity form, weekly drug consumption form and the distribution plan. After the first training round I did a second one in which I explained about the drugs in the kit2 and about the use of the autoclave and sterilisation techniques. In general the attention was good the doctors were motivated and asked questions. The level of knowledge was different and vary from comparable with our knowledge in the provincial hospital to very little in some remote counties.

  Visiting health structures
  Almost every day I visit ri-clinics and county hospitals to check the medicine stock and see how the patient were treated. Amongst children the most common diseases were diarrhoea, respiratory tract infections, skin infections and dyspepsia. I also saw some operations, the indications were appendicitis, amputation due to gangrene, ileus and ectopic pregnancy. The conditions in which the surgeons had to operate were very
difficult. No infusions, almost no analgesics and very little equipment. In the hospitals there was no RX and almost none lab facilities.

- epidemiologie

The results of my efforts to collect data were very poor. With a lot of efforts a received the morbidity and weekly drug consumption form of one month. The collected data were not reliable. From my visits to the hospital I know that the Koreans have their own forms for stockkeeping and morbidity maybe we can ask them to use those data. At the moment they are doing two bookkeepings one for us and one for themselves.

The programme

My personal feeling is that the programme has been a success. The drugs we have distributed have reached the people who need it. The use of the drugs and of the medical equipment is reasonable good. Of course the doctors need more training and information about the drugs and treatment of the diseases but they are eager to learn from us. The collecting of data to proof this is much more difficult. As I have told before they have their own system of stockkeeping and there own forms so may be we could use them. For the moment the only way to check if the distribution is done well is to go into the field. For the future I think it's important to decide what our priorities are because we can't support the whole health system. My personal feeling is that we should focus on the ri-clinic level. We simply don't have the means to support all the hospitals and we will reach much more people by supporting the ri-clinics than if we focus on the hospitals. During my stay in the DPRK I have noticed more openness and thrust between the Koreans and MSF, for me it's important that this process doesn't stop and the mean condition for the extending of the program. One of my main disappointments during the last five months was the lack of co-operation and thrust between the three MSF sections. If you decide to act as one mission in the DPRK than do so. At the moment there are three different policies, three different budget, three different salaries, three different per diems, three different R$R arrangement, etc. Needless to say that this put I lot of stress on the team. I believe that the responsible persons should act more professional on this matter.

Greetings

Herbert

1.3 MSF-F: Rickard Ljung.

Medical report KANGWON PROVINCE FEBRUARY 1998

Distribution

The difficulties with incorrect distribution of KIT 1, KIT 3 and the SUPP KIT have been sorted out. I have had several meetings with the director of Public Health. I have now finally received the actual distribution of the different kits, this plan does not exactly correspond with the MSF distribution plan. The changes done by the Public Health department have been in favour of Wonsan city. I have made my opinion on this very clear and hope that there will be
less problems in the future. I will do changes in the next distribution by reducing the drugs for
the Wonsan city hospitals as they now by these unauthorised changes received more than they
were supposed to.

The blankets and sheets have arrived. As they arrive now when winter is over is very
embarrassing for MSF, even worse is their bad quality. The order of the blankets and sheets
was worth about 150 000 ECU. That the blankets could not be delivered on time and that they
do not fulfil the required standards is for me difficult to understand, there must have been some
misunderstanding between us and the Europe desks. 2700 of 7700 blankets have arrived in
Kangwon, not yet distributed.

The KIT 2 have arrived in January but have now at last reached the provinces and
distribution will soon begin. Milk has been left in the provincial warehouse, and not distributed
for one month despite the fact that some hospitals had run out of milk. The BP-5 arrived in the
province the last week in February but they are distributed by another department then the
drugs.

The difficulties with distribution is not only lack of transport. In my province there is,
as seen above, a deliberate change made in favour of some hospitals. This month has been
disappointing for me, I have encountered more problems than before with the monitoring of the
drug distribution.

Training

After the completion of the training on the antibiotics I started to do training on the
remaining drugs of the Supp Kit. As I during this did evaluation of the previous training I
realised that the hospitals do not use the drugs as they should. There is usually an
overconsumption of injectables and broad-spectrum antibiotics e.g. chloramphenicol. The
pharmacy and store room records are done in (at least) two different books, one for MSF and
one for the hospital. Therefore I stopped training on more complex drugs. I have now put more
emphasis on how to run a pharmacy. It is sad that so much time is spent on subjects they should
know before than on real medical training. We have also completed the training on how
to use the autoclaves, sterile gloves and chlorine as a detergent. It is difficult to decide what to
train on, the options are many! All counties have received 20 guidelines in Korean for the
Supp Kit drugs.

Data

I have received the drug consumption lists and morbidity charts per county for the
month of December. As suspected the figures are not reliable. When told about this the director
of Public Health admitted that the numbers were fake. According to the charts all counties had
used up all drugs of the KIT 1 for the month. The morbidity data is more complex to analyse
and I am not finished with the evaluation of this, one important factor is that the prescription by
the doctor, for all medicines, is done for two days at a time only. This means that patients must
come back to the doctor on day two to get a new prescription for the next days. This must
certainly have an influence on compliance with the effect of misuse of antibiotics. It also
means that in a week several patients are counted “doubled” in the morbidity form. I have also
got the numbers for January but they are not analysed yet.

Access

The winter is turning into spring, the snow is nearly gone but the roads are still very bad
due to mud, despite this we have been able to visit all counties. We have visited they orphanage
of < 5 years and the one for > 5. We have repeatedly been denied access to the TB sanatorium.
The mission

The nutritionist working in Kangwon left on Feb. 28 and the last week in February her replacement was introduced to the province. There has been more changes within the team with both of the MSF-H members being replaced.

Future

I will do more training on pharmacy and stock keeping. Start the distribution of KIT 2. I will leave the mission as planned on March 28, and I will hopefully have one week of handover to my successor. The most exciting will be to get the director and the desk of MSF-F to DPRK. The objectives and the strategy of this mission is still very unclear. I have been here for three months and I don’t know if I really do something sustainable or if I am just here for distribution of “drug dumping”. As said before I see a need for medical co-ordination and also co-operation between the three desks.

Rickard Ljung
Doctor Kangwon Province
March 1 1998

2. Nutrition

1.1 MSF-B : by Brigitte Noel.

NUTRITIONAL REPORT - SOUTH PYONGAN PROVINCE
FEBRUARY 1998

INTRODUCTION

During almost two months we were not present in the Province. However, thanks to Fiona and Rickard for the two trips they did to Pyongsong Paediatric Hospital and Taedong County Hospital to visit the TFCs. During this month of February we went all around the Province to reevaluate the situation we left in December. The TFC’s were not running out of milk and they continued to receive a few children during the winter.

COMMENTS ON STATISTICS

The table give an overview of the admissions in the Province till the end of January 1998. Total for the four months = 1,482 children.

October = 182
November = 387
December = 614
January = 299
NEW ADMISSIONS in TFCs - SOUTH PYONGAN PROVINCE
October, November, December 1997
January 1998

>5 years
20%

Severe malnut.
32%

Moderate malnut.
48%

Total new admissions: 1482 children

NB: The percentages are calculated using the statistic datas. Percentages of severe and moderate malnutrition correspond to children less or equal to 5 years old. Around 90-95% among the above 5 years are severely malnourished.

Statistics are in the file Bxl.xls.

1.2 MSF-H: by Inge Verdonck.
In fact, it is not her monthly report but her final report.

Final report Nutritionist MSF-Holland

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The Nutrition Situation in North Hwangae Province

Background on the health situation

The health system
The health structure in the DPRK has the following levels. At the lowest level are the Ri (sub-district) clinics, a kind of primary health care centres with doctors, nurses midwives and sometimes a dentist. The clinics normally cover a population of about 3000 people. Each doctor is responsible for a group of households, nurseries etc.

If the patient cannot be treated in the clinic, and the clinic is far from the county hospital, he can be referred to the Ri-hospital, which are a bit bigger than clinics and have a few beds (which were hardly ever used during our visits).

From the Ri-hospital patients are referred to the county hospital (or city hospital if the county is a city) and from there on to the provincial hospital.

The clinics and hospitals are basically rather empty buildings with doctors and a few patients. There are only traditional Korean medicines (only useful for certain diseases according to the doctors), hardly any medical equipment, no running water, some times electricity (only a few hours a day in some places), hardly any fuel, few mattresses and blankets and too little food for patients. In most health institutes they explained the lack of everything with flood damage, but it also shows the total collapse of the system.

On the positive side, there are many doctors.

**Main health problems**
The main health problems were diarrhoea and respiratory infections. For more information on the health problems see the reports from the MSF doctors.

**Background on food situation**

*Food production*

According to the official account many things were destroyed during the floods in 1995 and 1996, while the drought in 1997 caused a low harvest for corn. In September I could see that much of the corn in the field was in poor condition indeed. The rice looked good, and most officials said that the rice harvest was not bad.

More natural disasters can be expected, since most hills are completely denuded from forest and agricultural fields are made on steep parts of the hill which are unsuitable for cultivation. Contour planting and terracing is practised, but I doubt whether this is sufficient to protect the steep hills from erosion. Increase in production is hampered by lack of fertiliser (the compost which is put on the field does not look very fertile), lack of mechanization and "the system" (much energy is lost in useless activities) and possibly lack of irrigation (irrigation water must be pumped, there might be lack of fuel but I could not observe this in this time of the year).

Almost every square centimetre is used for food production. Road sides, squares in hospitals, and gardens around houses (including roofs which are covered with squash vines). Many people live in high-rise buildings, where they use balconies for growing vegetables or keeping chickens. Green houses are common, most hospitals have a green house in which they grow vegetables. I saw most often oxen (as working animals), I also regularly saw goats, less often chicken and least pigs (but these are of course more often penned and not visible from the road side).

During our lunches we often receive ‘wild’ food like wild plants, mushroom, honey and fish. We could often see people gathering (food?) on the hillsides along the road, but I do not know how much these wild foods contribute to the average diet.

*Food distribution*
The farmers normally get a percentage of the harvest of the co-operative (once a year after the harvest). Other people get food from the Public Distribution System normally regularly during the year. Everybody said there was lack of food. I could not get much detailed information on this. Most people and hospitals have only rice or corn and cabbage, other food is scarce. It is clear that there is a big distribution problem. WFP and other organizations distribute food. But the logistics of distribution is a problem. The BP5 which arrived in December in Pyongyang for distribution in the hospitals had only reached half the county hospitals in the province two months later. WFP is the first to agree that monitoring is also a big problem.
Most hospitals lack food, there is sometimes not enough to feed the mothers who stay with the patients, which contributes to the high defaulters rate. There is little other food for the second phase treatment of malnourished children, so that much expensive HEM is used in the second phase, where cheaper food could be used.

Consumption patterns

I have very little information on this. According to our translators our lunches consisted of the normal kinds of food, like meat (mainly chicken or goat, sometimes beef or pig and once rabbit, deer and pheasant), fish, vegetables (fermented cabbage, spinach, sprouted beans and wild roots or leaves), often mushroom (wild and cultivated), egg, bread, rice and soup. As snacks we got often apples, pears, sweet potato, chestnuts, and other fruits and nuts. Although this kind of food might be or might have been usual, the interviews showed that the people do not have this variety of food at the moment.

The main food in North Hwangae province is rice and kimchi (fermented cabbage). All people interviewed said they eat this daily. Other foods they have sometimes. Due to lack of food, the diet has probably become less diverse and less energy dense. Meat, eggs and other supplementary food is scarce (on the other hand wild food might be a new contribution to the diet, it might not be appreciated enough and therefore seldom mentioned). Some people claimed they eat more often 'porridge' to let the grains last longer.

Alcohol is cheap and part of each meal, it is consumed in large quantities by men. Almost all men are heavy smokers. The women I saw, did not smoke and drank small quantities of alcohol if any. The translators said that after the fertile age some women started smoking and drinking.

Hygiene situation

The people say that much of the drinking water system was destroyed during the floods. In September I saw few people carrying water, maybe they had a source next to the house. Since November the rivers have dwindled to small streams and others sources might have dried up to. Now you can see everywhere people carrying buckets of water. Many people collect water from wells (sometimes the well can be easily polluted because there is no wall around it), but also from the rivers or holes in the river bed or any other source of water.

Most hospitals have no running water. There is often a water well on the hospital compound. Patients can not be bathed, there is no water in the rooms for the mothers to wash their hands (for instance after changing diapers). In some doctor's room is a small basin with water, but I did not see doctors washing hands. There is only MSF soap and chlorine in the hospitals. The toilets inside the building are out of use and patients have to use pit latrines outside the building. Most houses have also pit latrines.

Malnutrition situation

According to the officials there is 15% malnutrition in North Hwangae. Some counties and some ri's (sub-districts) are more affected than others. However it is not clear on which criteria this figure is based. The traditional criteria is weight for age and the reference criteria for these are different in most counties, although all give a lower weight and height for age than international standards (see my report weight for age in DPRK). I doubt if they have ever done a survey on malnutrition. Only recently they have done a 'malnutrition campaign' in a few counties.

From the patients we see in the hospital we can notice the following:

- There is probably a chronic malnutrition problem. Almost all children are stunted (besides actual malnutrition), often severely stunted (under -3 S.D. H/A). Older children and adults are also stunted, which show that there is a chronic nutrition problem.
- Many malnourished children are under 1 1/2 year old. They are probably malnourished because of poor breast feeding and weaning practices (see my report on this).
- I talked to a few MUACs of mothers of which the hospital staff said they could not feed because the mother would be malnourished, but all were above 22 cm, which showed they are not malnourished. Which might mean that lack of food is not the main problem.
- There is a large variation among the counties and the seasons in the rate of oedema versus marasmus. Which might show difference in main causes of malnutrition (the doctors confirm that children with kwashiorkor have more often a history of diarrhoea), but it might also show a difference in admission criteria.
Nutrition co-ordination
I initiated nutrition co-ordination meetings, in order to improve the co-ordination among the international organizations in the field of nutrition.

Background on working conditions

Introductions and counterparts
In North Hwanghae the people already knew MSF from an earlier mission in 1995 in the county Unpa. They therefore already knew what to expect from us, which made the introduction easier. During our first round to all the counties we were accompanied by the head of the provincial health department. During the following months we would see him regularly and discuss the programme and the problems with him. We only met the head of FDRC a few times during the first weeks. In the counties we were normally accompanied by the director of the hospital, the head of the health section and sometimes (vice) chairman of the county. This made it easier to discuss more general health issues. The negative side of being accompanied by so many people was that it was sometimes impossible to have discussions or training with the doctors or patients. In the other provinces the teams were accompanied by other people. For instance in Kangwon they had the first months a doctor with them, who could initiate actions (like replacing non-functioning heads of wards), which was more difficult for us.

Access to health structures and other institutes
We normally went four or five times a week to the counties. We had to present our weekly programme on Friday morning a week ahead. We had no problems with access to the counties and hospitals. Although most visits were therefore pre-arranged, sometimes we would come unexpected because the county was not warned in advance by the FDRC about our visit, in which case we did not notice much difference in the situation (people were only less prepared and we had to wait longer till doctors were ready to show us around).

It was more problematic to have free access to the clinics if we wanted to do random visits. Partly because the road conditions were not good enough and partly lack of time (may be intentionally caused by the counties). We could do some random visits, but we had to fight for it.

We could visit nurseries when we put it in the programme (not at random, they are not under the department of health). We also regularly visited the provincial orphanage for younger children and once the orphanage for older children. We could not visit any other health structures (disabled, retired, TB hospitals). We tried to arrange visits through provincial level (impossible because they do not fall under the department of health, our counterpart) and through FDRC in Pyongyang.

We were not allowed to go anywhere by ourselves, but had always one of the translators with us.

Lunches
The food is very nice in DPRK, but the people in the counties are too hospitable. Each day we got a big lunch which took at least one hour. During the first month we even had to rest for an hour after lunch, which left little time for work.

Gathering background information
During our visits I interviewed doctors and patients. Most of the information was not very useful because of several reasons:
1. Nervousness: Especially during my first visits most people were too nervous to answer me because it was the first time they saw foreigners and because many higher officials accompanied us. Later this was hardly a problem, since the doctors had at least seen us during the training, and patients had heard about me from other patients. The faces of patients showed that they were even disappointed if I did not talk to them.
2. Instructed answers: I had the clear impression that the doctors were instructed beforehand on what to answer to us on certain topics, since all gave the same answers. For instance in all places there was 15% malnutrition, but apparently the instructions did not specify among which age group, since if I asked about this, I got different answers, and some did not know what to say.
3. Lack of knowledge: Some answers were doubtful, because probably the doctors were also not aware of the real situation. For instance the percentage of malnutrition and the number of patients seen did not fit (the doctors have not a real idea about the percentages of people with a disease). And probably no one knows the real malnutrition figure because no one did systematic research it. The
numbers of patients with vitamin A deficiency are higher and of anaemia are lower than I expected under the circumstances. Is this real, or lack of recognition of clinical signs and diagnosis techniques? I had the feeling that normally in the DPRK programmes are not based on information about the actual situation (e.g. stock cards are also new, they normally get stuff if this is available, not because stocks are going down), therefore people probably did not understand the importance of our questions.

4. Politics: Many answers are politically sensitive, so that reality cannot be discussed.

5. Expectation: Many times doctors say they do not have something because they presumably hope MSF will provide it (add this to the problem of politically sensitiveness to admit that they do not have something, and you will never know how to interpret an answer).

6. Systematic information: We had permission from the Head of the Department of Health to distribute a questionnaire to all doctors of the clinics during the training (mainly questions on morbidity figures). But after the first time, when FDRC in Pyongyang heard about it, it was forbidden to ask these questions in this way. We could only ask it in individual interviews in clinics, probably because this would give less systematic information.

7. Interpreters: Last but not least, all information goes through the interpreters. They might change some information because of political reason. They might forget to translate things because they do not understand this might be important for us. They might translate our questions differently (for instance in a suggestive way) because they do not understand interview techniques. Their English is not good, so that they have often problems to translate correctly.

To make a long story short, it is very difficult to gather reliable information in the DPRK. So most information in this report is based on my feeling whether the information is trustworthy, logic and confirms my observations, in other words my personal opinion.

The only way to get better quality information is if FDRC is convinced that we can only run a good programme if we have better knowledge of the situation.

**Evaluation of my tasks**

- **Start therapeutic feeding centres in the provincial hospital and in county hospitals depending on nutritional data.**

  In the provincial hospital and county hospitals the TFC have been started. In most TFCs the treatment of the malnourished children was quickly learned and most children showed reasonable progress. There is a wide variation in the functioning of the TFCs, which is mainly related to the motivation of the staff and the support the hospital gets from the county (in the form of fuel and food). An important part of my visits was therefore to motivate people.

  It was not possible to get reliable nutritional data.

- **Plan in co-ordination with provincial authorities possible supplementary feeding programmes.**

  This has failed because first of all the MSF co-ordinator told me that I first had to establish the TFCs and there would be no time left for me to get involved SFC.

  I do believe that SFC are more appropriate than TFC in this country (see below) and I have pushed this idea.

- **Give training, especially practical, about nutrition at different health levels.**

  I have focused my training on establishing TFCs and the referral system for malnourished children.

  At the TFCs I have trained on many nutrition topics, and given advice for practical problems for observed problems.

  I gave a short training at clinic level regarding prevention of malnutrition.

  I believe that much more training will be useful. However, I found it difficult to train without knowing more about the actual circumstances. I therefore spent much time on gathering information on actual practices. I have left a report for my successor about the identified training needs.

- **Install a referral system of malnourished towards county and provincial hospitals.**
In fact a clear referral system exists. I trained the clinics and hospitals about new criteria to refer malnourished children. However the implementation of the referral system is not perfect. The main problems are that the hospitals do not have room to admit all the children, that the mothers do not like to stay in the hospitals (see also below). Besides most clinics do not have measuring boards to implement the new W/H criteria. However the newly introduced MUAC tape is widely used and solves some of this problem.

- **Do follow up of nutritional situation in the province.**
  I did my best, but I know this is not good enough to get reliable information (see above).

- **All this in close collaboration with directors of public health of the counties and with hospital directors.**

They accompanied me during visits, and I discussed all aspects of the programme with them.

The main problem is to get feedback. I started each visit with the open question 'how are things going' and 'are there any problems'. Invariably there were no problems and all went well. However during the visit I noticed many irregularities, and underlying problems were only then explained. It was also impossible to get ideas for the programme. For instance my questions on possible ways to reach more malnourished children was normally answered with 'we will do our best'. But no ideas were given how.

**Nutrition co-ordination meetings**
I initiated nutrition meetings because I felt that a better co-ordination among the agencies would improve the nutrition programmes of all concerned.

The first inter-agency nutrition meeting was held in January. It was followed by five other meetings on specific nutrition topics. The meetings were well attended and appreciated by the nutritionists. They were very useful for all nutritionists to share their experiences, to advise each other and to improve contacts in general. The meetings helped to introduce a consistent nutrition policy which was approved by the participants.

Because of the success of the nutrition meetings the medical specialists started similar meetings.

There were some 'political' problems with some organizations concerning these meetings, but these have been well addressed by the MSF co-ordinator.

**Evaluation of the nutrition programme**
I think the description of the nutrition programme is a little meagre. The fact that there are no objectives makes evaluation problematic. This might fit in the MSF philosophy 'we just go for it'. However, after half a year of 'going for it', I think I spent a few minutes on reflecting the programme.

I first will give a few comments to the programme as described in the MOU.

When I came there was only HEM in 4 places in my province, not enough to run a programme. There was no alternative plan, which made us dependent on UNICEF's good-will. Luckily we got HEM from CAD.

Next it was unclear why we have to be a liaison between the centres and UNICEF and WFP. Although we reported to them our findings in the field, I do not think people in MSF, UNICEF or WFP agreed that this was our main function, since UNICEF and WFP have their own monitors. So I would not have put it as one of the main components in such a short programme description.

**Are TFCs in county hospitals the best solution?**
Although no objective is given in the MOU, I suppose that the main objective to start the nutrition programme is: 'to address the nutrition problem and to treat malnourished children in the most effective way'.
I think too little information was available when the programme was defined to say that TFCs are the best way to address this objective for MSF.
In December we got a new co-ordinator, which improved the situation. However, understandably, it took some time before she was completely introduced to all aspects of the programme. So now I am leaving, finally the nutrition programme can be discussed.

The work in DPRK has been very interesting. The work has been very diverse, practical and rewarding. It involved getting an understanding of the actual health system, and adjusting to this in the most suitable way to get an effective programme. The close collaboration with doctors in many institutions was very interesting. The work in different hospitals gave a diversity of experiences, which gave many in-sights in the functioning of the health system.

Although the system, the suspiciousness of the people and difficulties to get real information, were often tiresome, I very much liked to work with the Korean people. The doctors are very motivated, it is encouraging to see how they do their best under such difficult circumstances. It is a pleasure to provide them with the means to do their work well, and to see the impact of our inputs on the treatment of the patients. It is heart-warming to seen their gratitude and hospitality towards us.

I particularly enjoyed to work in a team with colleague nutritionists, which made it possible to share experiences and learn from each other. I very much appreciated the back stopping from HQ through Saskia van der Kam. I was very glad with the possibility to join the workshop on assessment of food security, it has been very interesting and useful for my work here.

Inge Verdonk
Pyongyang, 27/2/98

1.3 MSF-F : Fiona Laird.

Summary report for Kangwon province October 1997- February 1998

Overview

The MSF nutrition programme started in Kangwon on the 1st of October. Initially the role of the nutritionist was to provide training and support to the hospitals where UNICEF had provided therapeutic milk. However, milk was absent in all but four hospitals, therefore MSF acquired its own milk supply, from Children’s Aid Direct, and distributed 28 tonnes to 12 city/county hospitals in 11 counties from the end of October. Training was given to all these hospitals on the use of the milk. Training was also given to the clinic doctors on the use of weight for height charts, use of MUACs, and the criteria to refer children for therapeutic feeding. In the absence of adequate food supplies at home, both severe and moderately malnourished children were included in the admission criteria. (i.e. all children of less than 80% weight for height.)

The number of children attending the feeding centers in November and December was good - 2,000 fed in two months. Many health structures did not have enough beds for this number of children and used ‘overflow’ feeding centers, usually in nurseries or kindergartens, for the moderately malnourished children without other disease. Numbers of children in each centre are now less, apparently because the majority of severely malnourished children have now been treated.

TFCs
In the beginning of October, the hospitals contained few children and those present were usually severely malnourished. The hospitals that did have therapeutic milk had more children, but feeding was disorganised, and unstructured. It required on average three visits to each county hospital to clarify feeding protocols and establish understanding of how to use the milk (three months to cover the entire province.) Staff have a good academic background and were keen to learn. Difficulties of non-compliance usually arose through fears that milk supplies would be limited.

Training on referral is difficult to evaluate, as an established referral system from clinics to the county hospitals already existed, and in Kangwon, the greatest numbers of referred children were seen in two counties where training was not given. (Visiting was denied for six weeks due to military sensitivity.)

Most of the hospitals are now using the therapeutic milk well, and attendance numbers have been good, but are now falling. There were delays in the second distribution of milk during January, arising from a late request by MSF, and then transport difficulties. However, distribution of F-100 from the Wonsan warehouse has not been fulfilled for over a month despite a request for urgent distribution of milk to the structures that were running out. Two of these hospitals were within Wonsan City, so the excuse of transport difficulties is lacking in credibility. It seems that there is little incentive to feed urgently any more, and there is a lack of commitment from authorities in Kangwon to maintain feeding.

Most of the hospital staff report that the severe cases of malnutrition have been treated, and numbers attending the hospitals are reducing, but I do not believe that all children have been treated. Hospital staff will admit that referral of children who live far from the hospitals is not so good. The exact reasons why children do not attend is not clear, but presumed to be the obvious ones, travelling distance, cold etc., although there may be a more complex agenda, perhaps political that we cannot understand.

The nutrition team had proposed to open secondary TFCs in the ri-hospitals in order to overcome difficulties of distance, and in one county, this has been started. However, the picture emerging is now that a supplementary feeding programme would be of more benefit that extension of the therapeutic programme. Use of an alternative food to HEM would be cheaper, and easier to implement and monitor on a large scale. It would also be more suitable for the child to remain at home, both in terms of the environment for the child and the co-operation of mothers. Throughout the winter, the hospitals have been very cold, transport to the hospital is difficult, and many mothers have other obligations, such as other children to care for. There is rarely a good water supply in the hospital, toilets are usually outside, and as a significant proportion of the children have diarrhoea, the risk of cross infection is very high.

**Malnutrition**

The picture of malnutrition in Korea remains a confusing one. Between counties there are significant variations in the type and degree of malnutrition seen in the TFCs. (Data in Table 1).

*Several of the counties had 50% kwashiorkor.*
*Some counties have exclusively children under five.
*A few counties have a very high incidence of severe malnutrition in older children.

Visually, stunting is also a widespread problem throughout the province, and frequently children in the TFC are short, revealing both chronic and acute malnutrition. There is often a discrepancy in classification of severity of malnutrition, depending on whether MUAC <110 or weight for height <70% is used. Frequently children of greater than 70% weight for height are seen with MUACs of less than 110 mm. (I don’t know the exact implication of this finding, or whether it is significant.)

Causes of malnutrition are still not clear. Hospital staff always give lack of food as the primary reason, but the fact that mothers are rarely malnourished implies that the problems are more complex. Other factors that require consideration include:

**Breast feeding/weaning.**
Mothers that cannot breast feed adequately visit the clinic doctor, and sometimes the midwife. It is not exactly clear how much encouragement and advice is given to the mothers to try and overcome difficulties, but there does not appear great commitment to breast feeding, when problems arise. Rice porridge is used as a substitute even for the newest babies, and also as weaning food. It is known that protein sources are rare, and it is easy to imagine that some children are weaned almost exclusively on this rice porridge. Other factors may be significant, for example mothers go back to work, and only breast feed morning and evening, therefore milk supplies dry up.

**Water**
In Kangwon province most of the Koreans consider the water quality to be good, and several areas produce bottled mineral water. However, many people are seen carrying buckets of water from streams that do not look to be of this quality, and the impact this has on health must be questioned. Diarrhoea is of course a very common feature in the malnourished children, and although the causative factors have not been formally assessed, water is frequently suspected.

**Disease**
The hospitals are almost totally lacking in equipment and resources, therefore diagnosis of illness is essentially clinical. In some cases, underlying pathology is reported as a causative factor for malnutrition, but it is equally possible that wasting is the first symptom of a undiagnosed disease. When older children are seen, they are usually more severe than the younger ones, which is an unusual picture. To date, all the deaths reported have been of older children, and 4 of the 6 had oedema.

Tuberculosis is still a taboo word in this country, but a few brave souls are prepared to talk about it. Apparently, TB had been more or less eradicated prior to the floods, but it has re-emerged in hand with the malnutrition. X-ray confirmation of the disease is usually impossible due to lack of film, but suspected cases are referred to the TB sanatorium for assessment. We have had one report that there are 40-50 paediatric cases in the Kangwon sanatorium. MSF asked to visit this, but at present has been denied access.

**Orphanages/ Children’s centres.**
Orphanages are generally referred to as children's centres, although not all of the children present are orphans. Some children will attend if they come from single parent families, and the parent cannot care for the child adequately, or if demands of work are excessive. There is one children's center in each province. Apparently children from the age of 6-11 all children then go to a center in 'the North' and then they return to Kangwon province to the secondary children's center when aged 12-17. (This nomenclature confuses me too!)

UNICEF provides for the children's center in Kangwon. MSF is not formally operational in the center, but with the agreement of members of the UNICEF team, we have offered clinical and technical support for therapeutic feeding. This is in part because geographically we are in a very strong position to do so, and also because practical support is not otherwise available. However, there is some ambiguity for both the staff of the center and the MSF team about how involved to be, for example, UNICEF has failed to respond twice to information from MSF that the UNICEF milk supplies were running out, and so milk was provided by MSF as an interim emergency measure.

The children's center has 280 children, from 0 to five years old living on two sites. Until today, I had visited the centre about once a month, and was unaware that the second site existed. The condition of the children in this house is distinctly worse than I had previously seen, and many of the children look to be developmentally delayed, as well as undernourished, and suffering from minor diseases. There are usually about fifteen to twenty children in one room, with one carer/nurse children. Therapeutic milk is being given to the majority of the children. The director of this center is very charming, and appears to care for the children, however, I believe that this institution would benefit from more regular attention from the agencies.

Until recently the existence of the institution for older children had been denied. In part this seems because the orphanages are an emotive subject, and attract a lot of attention from would-be humanitarian sight seers. There has therefore been reluctance to allow entry into these institutions, but this further fuels speculation about the condition of the children.

The Kangwon secondary children’s centre apparently houses 800 children, and the building is very large, so this could be possible. The director commented that the government provides food, but there is not really enough. 15 children have been referred to the Provincial paediatric hospital for therapeutic feeding, and another 30 have been treated in the center. In a class room, two children looked as thought they would have benefited from therapeutic feeding, but there were also many adolescents playing ball games outside who looked fit and well. It is my biggest fear that we have unknowingly walked past rooms full of wasted children, but so far the impression from both visits is that these children are living in reasonable conditions.

The working context.

Difficulties in transportation have caused a major obstruction to the work of MSF, and nearly all distributions have faced delays. The fact that spring is arriving and we
are just starting to distribute blankets is not just disappointing, but becoming more farcical by day.

Communication is not always easy. There is often a reluctance to admit to problems, to get direct information or feedback, and sometimes there is evidence of ‘economy of truth’. Data is unreliable, and one county has given different data on three successive visits. Usually these problems can be overcome or dismissed quite easily. Unfortunately, there have also been elaborate charades, using malnourished children as the players, which are tragic, and disturbing to witness. Severely malnourished children are seen in a TFC, and then disappear, presumably back to the institution they came from. In all cases this has been seen, the children have looked particularly uncared for, with shaved heads. In Kangwon, I have seen this once only, and there were significant improvements made to the ward, including a change of staff, after I discussed with the director of the hospital that this was unacceptable. But these children still exist somewhere.

Distribution of the medical kits has not brought about the improvements in health care, that would be hoped for. The store rooms often remain full of unused equipment. Usually the paediatric ward, has one pair of gloves, if any, and systematic drug treatment of malnourished children requires constant pushing. The paediatricians are usually restrained by the instructions of the director of the hospital, but in turn, he too, is probably under orders. One doctor explained that he was using inadequate amounts of milk, because he an official (of what department?) had told him to use less. Unless this mentality changes, the work of MSF will never be successful in this country.

**MSF**

Until Christmas, working conditions within the MSF team were very difficult. Communication breakdown between the head of mission, and the MSF France doctor, Payam Fazel, led to Payams’ departure at the end of October, and left a legacy of disunity. An internal cold war existed within the team, and communication from the head of mission was negligible, or within MSF Belgium only. On a personal level, working in a country that is secretive, suspicious and mistrusting is not easy, but for me there was a feeling of ‘We have found the enemy, and it is us.’ Professionally, lack of communication has more significant implications on the effectiveness of the programme. The medical/nutrition members of MSF-F and MSF-H were on their first missions with MSF, and experienced leadership would have been welcomed. Now that communication and support are improved, the programme is gaining cohesiveness and direction, allowing a fuller analysis of our work.

**The Future**

The current nutrition program was appropriate when MSF first started working in DPRK, and there is no doubt that it has prevented the deaths of many children. This has been stated by the hospitals staff. However, I think that it is now losing effectiveness, and if numbers in the TFCs continue to fall, it may become difficult to justify continuing. I think steps need to be taken quickly, to adapt to the needs of the children being seen in the TFCs and to reach those children not being seen. The
proposed supplementary programme using dry rations seems appropriate, but needs to be implemented soon.

MSF has been privileged to have relatively large numbers of ex-patriate staff in DPRK, and has had comparatively excellent access to the medical structures and the population. We therefore have the most experience in implementing therapeutic feeding in DPRK. For this reason, I believe we have a lot to offer the children’s centres, and would like to increase the level of support that we can offer them. At the moment, doing so does not look easy, but having seen the children, I would fight to do it.

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Numbers often reduced, due to lack of milk. Kosan ran out of milk in the first week of January, therefore no new admissions.

3. Logistic:


Ordering.
The project is still in-between two budget periods of the southern projects and starting-up a new program in the north. No shipments arrived.

Transportation.

MSF cars.
Nothing to report.
Transportation of MSF goods.

MSF goods have been transported from the harbour in Nampo to the central MoPH warehouse in Pyongyang and from there on to the provincial capitals. 10 Tons of High Energy Milk has been transported by train to Chongjin in the North.

Distribution.
The blankets and sheets were distributed by the department for furniture etc. of the MOH and not through the normal drugs and milk channel. The distribution of them was very slow. The recipients and MSF-staff expected something else then the supplied emergency blankets and a general feeling of dissatisfaction was felt. The FDRC felt insulted by the quality. The project co-ordination explained that this were the normal standard emergency blankets of MSF. For hospital use these blankets are indeed not the most suitable.
The MSF warehouse is now empty apart from the items we don’t intend to distribute at this moment.
“Our warehouse” and storage containers are now used for material from UNICEF and MDM. It will be good that our material is gone because the MOH will now have to concentrate on the other material.
Still planned distribution:
20.5 tons of milk and 5 containers of KIT 1. (will arrive 1/3/1998)
A stock take was finally done.

Field visits.
No field visits have been made apart from a long trip to Chongjin to start up the program there. Travelling through the DPRK is however educational.
On the way the hotel in Wonsan where one of the field teams stays was visited. Their hotel is very cold and the electricity situation very poor. I only became aware of this fact the week before and had a look into things. Last week the generator was installed and gas heating which could be used was not installed because it turned out to be impossible to buy a gas bottle. Just now the spring started and temperatures rise steeply so the urgency has diminished.

In Chongjin a whole new project had to be set-up and together with the new logistician I went there. North Hamong province is further up north and much colder still. The road along the east-coast is very bad and through the mountains not more than a single lane track. The road is dangerous and not suitable for large scale transport by truck. Lots of snow and ice made the road even more dangerous and for long stretches snow chains had to be used.
We arranged hotel accommodation and warehouse space and looked into the facilities of the harbour, airport and railways. Chongjin is a very far out place and nothing compared to Pyongyang. The project will have to be self-sufficient because of it’s location. (3 day trip in winter).
Having a logistic person on the spot is an absolute must.
Back in Pyongyang supplies for the north were bought and the new team was sent off. For this we had to borrow a car from the WFP and we used one car of the southern program which got replaced by a car from the EC for some days. (cooperation between agencies is very good here).
Climate.
Winter seems to be over at the end of this month with temperature of 15 degrees during the day in Pyongyang. The road up north was reported to be free of snow and ice now but muddy. Spring rains started.

Lieuwe Montsma.
Log-cor.
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NEW ADMISSIONS IN TFCs - SOUTH PYONGAN PROVINCE
Conclusions:
Datas are not reliable enough.
We do not reach a lot of children. The average attendance per TFC is low for severely malnourished children.
It seems that only one TFC in the County Hospital is not sufficient to cover all the children in the County.
The County Authorities often ask to set up other centres, in mining hospitals or in rural hospitals, because they think that a lot of children will be able to attend the treatment.
The situation from one County to another can be very different for a lot of reasons: motivation of the authorities and the medical staff involved in the programme, availability and quantity of food in the hospitals. We treat a lot of moderately malnourished children in the TFC. The HEM is not a final solution to solve the problem of malnutrition. Cost, availability....
The underlying causes of the low attendance in most of the TFCs are unknown (distance, political reasons, motivation, prevalence of malnutrition, conditions in the hospitals....)

It was decided from now to find new alternatives on the field to try to make the programme more efficient. First to extend the number of TFC in each County or at least where they ask for to find and increase the number of beneficiaries. In a lot of places they started also outpatient distribution (for moderately malnutrition), it seems that it is more convenient for the mothers.

At the end of April, after 6 months programme we will have another evaluation. At this time we will get also figures for North Hamyong Province and from South Hamyong Province where MDM is working. If the situation remain the same (low attendance) we will have to consider maybe a new programme as SFP for instance, which seems to fit better with the actual situation.
We will write a SFP proposal with food supply from WFP in case we have to modify the programme.

Brigitte NOEL
MSF-B
Medical report KANGWON PROVINCE FEBRUARY 1998

Distribution

The difficulties with incorrect distribution of KIT 1. KIT 3 and the SUPP KIT have been sorted out. I have had several meetings with the director of Public Health. I have now finally received the actual distribution of the different kits. this plan does not exactly correspond with the MSF distribution plan. The changes done by the Public Health department have been in favour of Wonsan city. I have made my opinion on this very clear and hope that there will be less problems in the future. I will do changes in the next distribution by reducing the drugs for the Wonsan city hospitals as they now by these unauthorised changes received more than they were supposed to.

The blankets and sheets have arrived. As they arrive now when winter is over is very embarrassing for MSF, even worse is their bad quality. The order of the blankets and sheets was worth about 150 000 ECU. That the blankets could not be delivered on time and that they do not fulfil the required standards is for me difficult to understand, there must have been some misunderstanding between us and the Europe desks. 2700 of 7700 blankets have arrived in Kangwon, not yet distributed.

The KIT 2 have arrived in January but have now at last reached the provinces and distribution will soon begin. Milk has been left in the provincial warehouse, and not distributed for one month despite the fact that some hospitals had run out of milk. The BP-5 arrived in the province the last week in February but they are distributed by another department then the drugs.

The difficulties with distribution is not only lack of transport. In my province there is, as seen above, a deliberate change made in favour of some hospitals. This month has been disappointing for me. I have encountered more problems than before with the monitoring of the drug distribution.

Training

After the completion of the training on the antibiotics I started to do training on the remaining drugs of the Supp Kit. As I during this did evaluation of the previous training I realised that the hospitals do not use the drugs as they should. There is usually an overconsumption of injectables and broad-spectrum antibiotics e.g. chloramphenicol. The pharmacy and store room records are done in (at least) two different books. one for MSF and one for the hospital. Therefore I stopped training on more complex drugs. I have now put more emphasis on how to run a pharmacy. It is sad that so much time is spent on subjects they should know from before than on real medical training. We have also completed the training on how to use the autoclaves, sterile gloves and chlorine as a detergent. It is difficult to decide what to train on, the options are many ! All counties have received 20 guidelines in Korean for the Supp Kit drugs.

Data

I have received the drug consumption lists and morbidity charts per county for the month of December. As suspected the figures are not reliable. When told about this the director of Public Health admitted that the numbers were fake. According to the charts all counties had used up all drugs of the KIT 1 for the month. The morbidity data is more complex to analyse and I am not finished with the evaluation of this, one important factor is that the prescription by the doctor, for all medicines, is done for two days at a time only. This means that patients must come back to the doctor on day two to get a new prescription for the next days. This must certainly have an influence on compliance with the effect of misuse of antibiotics. It also means that in a week several patients are counted “doubled” in the morbidity form. I have also got the numbers for January but they are not analysed yet.

Access

The winter is turning into spring, the snow is nearly gone but the roads are still very bad due to mud, despite this we have been able to visit all counties. We have visited they orphanage of < 5 years and the one for >5. We have repeatedly been denied access to the TB sanatorium.
The mission

The nutritionist working in Kangwon left on Feb. 28 and the last week in February her replacement was introduced to the province. There has been more changes within the team with both of the MSF-H members being replaced.

Future

I will do more training on pharmacy and stock keeping. Start the distribution of KIT 2. I will leave the mission as planned on March 28, and I will hopefully have one week of handover to my successor. The objectives and the strategy of this mission is still very unclear. I have been here for three months and I don’t know if I really do something sustainable or if I am just here for distribution of “drug dumping”. As said before I see a need for medical co-ordination and also co-operation between the three desks.

Rickard Ljung
Doctor Kangwon Province
March 1 1998