

THE CRUMBLING STATE OF HEALTH CARE IN NORTH KOREA

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Cover photo: North Korean state poster reads: "With devoted effort by health workers, let's promote even higher the superiority of the socialist health care system!" Taken from David Heather's collection of North Korean posters. (CC BY-NC 2.0)

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1. INTRODUCTION AND SUMMARY

“We received 15kg of corn and 1 to 2kg of rice per month. To stretch our income, we made alcohol from the corn. We also ate the sediments from the corn alcohol. It was difficult to eat because of the bitter taste, but we were hungry and had to eat them. There was no choice. The leftover corn husks were used to feed pigs, which we also raised to earn extra cash.”

Lee, a 39-year-old woman from Chongjin, North Hamgyong province¹

In the early 1990s, the Democratic People’s Republic of Korea (DPRK or North Korea) faced a famine that killed up to one million people in a population that at the time hovered around 22 million (the current population stands at 23.9 million).² Food shortages and a more general economic crisis have persisted to this day. The government has resolutely maintained that it is committed to, and capable of, providing for the basic needs of its people and satisfying their right to food and a proper standard of health. The testimonies presented in this report suggest otherwise. The people of North Korea suffer significant deprivation in their enjoyment of the right to adequate health care, in large part due to failed or counterproductive government policies. These poor policies include systematic failure to provide sufficient resources for basic health care (North Korea had one of the lowest levels of per capital funding for health care recorded by the World Health Organisation in 2006). After nearly two decades, food insecurity remains a critical concern for millions of North Koreans. This has been compounded by the government’s reluctance to seek international co-operation and assistance, which the government is obligated to do when it would otherwise be unable to ensure minimum essential levels of food for the whole population, and its restrictions on the delivery of humanitarian assistance. This delayed and inadequate response to the food crisis has significantly affected people’s health.

Additionally, a currency revaluation plan in November 2009 caused spiralling inflation that in turn aggravated food shortages and sparked social unrest. In the first few months after the plan went into effect, the North Korean government exacerbated the situation by restricting the use of foreign currency, closing down food markets, and prohibiting small-plot farming. Many people died of starvation and many others lost their entire savings.

Amnesty International has documented how widespread and chronic malnutrition, which suppresses people's immune system, has triggered epidemics and mass outbreaks of illnesses related to poor diet. Interviews with North Koreans depict a country that professes to have a universal (free) health care system but in reality struggles to provide even the most basic service to the population. Health facilities are rundown and operate with frequent power cuts and no heat. Medical personnel often do not receive salaries, and many hospitals function without medicines and other essentials. As doctors have begun charging for their services, which is illegal under North Korea's universal health care system, the poor cannot access full medical care, especially medicines and surgery.

The interviews conducted by Amnesty International indicate that the North Korean government has also failed its obligation to provide adequate public health information. As a result, most of the interviewees were unaware of the importance of seeking proper medical diagnoses or completing a course of medication. And, because many hospitals no longer supply free services or medicines (despite government commitments to the contrary), many people normally do not visit doctors even when they are ill.

In a 2004 report, *Starved of Rights: Human rights and the food crisis in the Democratic People's Republic of Korea (North Korea)*, Amnesty International documented actions of the North Korean government that aggravated the effects of the famine and the subsequent food crisis, including denying the existence of the problem for many years, and imposing ever tighter controls on the population to hide the true extent of the disaster from its own citizens. It also documented the government's refusal to allow swift and equitable distribution of food and its imposition of restrictions on freedom of information and movement, which exacerbated the population's ability to search for food.³ Although some progress has been made since 2004, access to food is still a critical issue in North Korea. As this report demonstrates, the inadequate and sometimes counter-productive actions of the North Korean government over the country's food crisis have had a devastating impact on the health of the population.

Under international law and standards, North Korea is obligated to protect the rights of its population to the highest attainable standard of health. This means that, at the very least, the state must provide for adequate health care and the underlying determinants of health, including food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment. North Korea's responsibilities under international and domestic law will be addressed in greater detail in section 5.

To improve the situation, Amnesty International presents the following key recommendations to the government of the Democratic People's Republic of Korea with more detailed recommendations in the conclusion of this report.

Amnesty International calls on the North Korean government to:

- as a matter of priority, ensure that food shortages are acknowledged and effective steps taken to address these shortages, including acceptance of needed international humanitarian assistance;
- ensure the need-based and equitable distribution of health facilities, goods and services throughout the country;

- co-operate with the World Food Programme and donors, allow unrestricted access to independent monitors, and ensure non-discrimination, transparency and openness in the distribution of food aid;
- ensure that medical personnel are paid adequately and regularly so that they may carry out their duties properly;
- undertake information and education campaigns to provide accurate and comprehensive information on prevalent infections and diseases; their causes, symptoms and treatment; and the importance of medical diagnosis and effective use of medicines.

Furthermore, Amnesty International recommends to the international community, and in particular, major donors and neighbouring countries such as China, Japan, Russian Federation, South Korea and US to:

- ensure that the provision of humanitarian assistance in North Korea is based on need and is not subject to political conditions.

1.1.METHODOLOGY

For this report, between November 2009 and June 2010, Amnesty International interviewed more than 40 North Koreans, as well as organizations and health professionals who work with North Koreans.⁴ As the organization does not have access to the DPRK, the interviews were conducted with North Koreans who have settled abroad. In an effort to access the most current information, the interviews were selected based on the date of their final departure from North Korea (and not on their health background), with all but six having left the country from 2004 to 2009.

To protect the identity of the North Korean interviewees, their names have been changed. The majority of the interviewees came from North Hamgyong province and have since settled in South Korea. Although North Hamgyong is very poor, many of the interviewees lived near the Chinese border,⁵ and thus, had the knowledge, access and/or opportunity to cross the border into China and travel to the Republic of Korea (South Korea) for permanent re-settlement. Several interviewees had relatives in China and/or South Korea who had provided them with vital financial assistance. These factors may have given them better access to health care and services than the majority of the population elsewhere in the country. However, some of the interviewees had no family support in or outside North Korea. Thus, the findings of this report should be considered with these factors in mind.

2. BACKGROUND

“The progressive improvement in food security experienced by the Democratic People’s Republic of Korea (DPRK) between 2001 and 2005 has been reversed in recent years, and the country’s reliance on external food supplies is again increasing.”

UN World Food Programme⁶

2.1. FOOD AND ECONOMIC CRISIS

In February 2010, the Korea Rural Economic Institute, a South Korean government-funded research organization, stated that due to bad weather and lack of fertiliser, North Korea’s estimated shortfall for the year was 1.29 million tons of grain, equivalent to nearly four months of food supply. In its 2010 plan to provide assistance for 6.2 million North Koreans, the World Food Programme (WFP) was only able to raise 10 to 15 per cent of the funds, thus, covering merely 1.5 million people. According to the UN Special Rapporteur on the Situation of Human Rights in the DPRK, potential donors resisted contributions out of concern that the aid would not reach those most in need. In May 2010, the WFP announced that the drop in international donation for North Korea meant that food would run out at the end of June 2010.⁷

As “the right to health is closely related to and dependent upon the realization of other human rights”,⁸ including the right to food, and in view of the enormity of the food crisis in North Korea, health issues cannot be separated from the food insecurity that has gripped the country for almost two decades. Due to a combination of natural and manmade factors, including disasters, limited arable land, economic problems and mismanagement, and fertilizer and energy shortages,⁹ North Korea was hit by famine in the early 1990s, resulting in the deaths of about a million people, followed by food shortages, which are still ongoing.

Article 11 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), to which North Korea is a state party, recognizes “the right of everyone to an adequate standard of living for himself and his family, including adequate food” and provides, among other things, for states parties to take, individually and collectively, measures needed to improve methods of food production, conservation and distribution, including by maximum

utilization of natural resources, and to ensure an equitable distribution of world food supplies in relation to need.

Food insecurity exists when people are undernourished as a result of the physical unavailability of food, their lack of social or economic access to adequate food, and/or inadequate food utilization. Food-insecure people are those individuals whose food intake falls below their minimum calorie (energy) requirements, as well as those who exhibit physical symptoms caused either by energy and nutrient deficiencies resulting from an inadequate or unbalanced diet or from the body's inability to use food effectively because of infection or disease.

Malnutrition/Undernutrition is a state in which the physical function of an individual is impaired to the point where he or she can no longer maintain natural bodily capacities such as growth, pregnancy, lactation, learning abilities, physical work and resisting and recovering from disease. The term covers a range of problems from being dangerously thin (underweight) or too short (stunting) for one's age to.¹⁰

Article 12 of the ICESCR recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” and obliges states parties to take steps to reduce still-birth rates and infant mortality, provide for the healthy development of children, improve environmental and industrial hygiene, tackle epidemic, endemic, occupational and other diseases and create conditions for the provision of medical aid to the sick.

In August 2000, the UN Committee on Economic, Social and Cultural Rights (CESCR),¹¹ the expert body established under the ICESCR to oversee its implementation, issued an authoritative General Comment on that provision, outlining the core obligations of states parties to respect, protect and fulfil the right to health. This included ensuring “access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone”.¹²

2.2. FOOD RATIONS AND ALTERNATIVES

As a state party to the ICESCR, North Korea was not only slow to react to the food crisis, but took measures that aggravated the situation. For example in 1991, it reduced the amount of food rations through the state-run Public Distribution System (PDS)¹³ and launched a “let’s eat two meals a day” campaign.

Under the PDS, state officials and workers are allotted food rations, while farmers and their family members receive a portion of their own production. Since the mid-1990s, food rations through the government-run PDS and wages have either been suspended or dramatically reduced and sporadic when functioning. Food rations are especially prone to suspension during the lean months before the autumn harvest when the price of food also increases.

In the early to mid-1990s, the government actively encouraged the population to forage for alternative or wild foods, such as roots, grasses, stalks and tree bark, claiming that they were healthy and safe sources of nutrients. As the food shortages worsened, the population has been relying more heavily on wild foods and venturing to less commonly eaten varieties, some of which can be poisonous or cause severe digestive problems, especially among young

children and the elderly. By 1996, the UN estimated that wild foods accounted for some 30 per cent of the North Korean diet.¹⁴

In the lean months, households often mix wild foods with grains, such as corn or rice, in order to make their limited food supply last longer.¹⁵ A food and security assessment in 2008 by the UN Food and Agriculture Organization (FAO) and WFP found that compared to the 2003-2005 period, North Koreans' consumption of wild foods increased by nearly 20 per cent.¹⁶ It also found that wild foods had a negative effect on the health of young children:

“Diarrhoea caused by increased consumption of wild foods was reported to be one of the leading causes for malnutrition amongst children under 5, particularly in urban areas. Most hospitals and child institutions had limited ability to effectively treat malnutrition due to lack of fortified food for infants.”¹⁷

In October 2005, North Korea attempted to revert to the PDS as the sole source of grain (rice and corn) by clamping down on market activities. However, low food production, high fuel prices and infrastructure damage due to floods meant that food distribution was varied and erratic. Between 2004 and 2008, the latest year for which data is available, food rations ranged from 150g per day/per person to 350g. Just in 2008, rations went from 350g at the onset, reduced to 250g in May and to 150g from June to September, and increased to 300g in October.¹⁸

According to a survey by the WFP, those dependent on the PDS were more food insecure than farmers. Between 2003 and 2007, less than a quarter of PDS households and only two-thirds of farmers received their food rations, and rarely their full entitlement.¹⁹

2.3. INTERNATIONAL ASSISTANCE AND MONITORING

It was only in 1995 when the government finally made an appeal to the international community for food aid and assistance. But even after the UN and humanitarian aid agencies began distributing food and other essentials in the country, the government impeded their work on the ground. For example, North Korean authorities prevented the WFP and international aid organizations from accessing large segments of the population.

In May 1998, the North Korean authorities gave the WFP permission to distribute and monitor food aid in 171 of the 210 counties. This meant that the UN food relief agency was unable to reach 39 counties or 765,000 people, mostly women and children.²⁰ From November 1999 to November 2001, WFP access decreased to 163 to 168 of 211 counties.²¹ In December 2002, the WFP announced that the North Korean authorities prevented them from accessing 43 counties or 13 per cent of the population.²²

Between 1998 and 2000, four international humanitarian aid organizations, Médecins sans Frontières (MSF, 1998), Médecins du Monde (MDM, 1998), Oxfam (1999) and Action contre la Faim (ACF, 2000), withdrew their operations from North Korea. MSF, MDM and ACF cited restrictions on monitoring and evaluation activities, and the inability to direct aid to those most in need as reasons for their departure.²³ Oxfam halted its aid operation on clean water in and around the capital Pyongyang because of the difficulties assessing the impact of its aid programme in North Korea.²⁴

With the collapse of the PDS and mass job losses due to closures of factories and other state-run enterprises in the 1990s, many North Koreans suffered immense hardship and struggled

to survive. North Hamgyong province residents are the most vulnerable to food shortages due to the province's relative isolation, lack of arable land and significant number of factory closures. Moreover, urban populations in North Korea fare worse than rural households because of their greater dependence on PDS rations as their principal source of food and limited access to kitchen gardens or fields where foraging for wild foods would be possible.²⁵

Between 1995 and 2005, WFP's emergency operations in North Korea "directly supported up to one-third of the population".²⁶ Over the years, the UN food relief agency, adhering to a "no access, no food" policy,²⁷ improved its monitoring of food distribution in North Korea due to greater access within the country. The required notice period for visits by WFP teams was reduced,²⁸ while their visits increased in number with less paperwork required before the visits took place. The WFP was also increasingly able to choose the sites of their visit at random, thus, making them less susceptible to manipulation.

However, authorities still prevented Korean-speaking international staff from being involved.²⁹ In 2008, the WFP conducted a crop and food security assessment for planning and responding to food security needs and access to vulnerable groups. A year later, this assessment was stopped by the government, again raising concerns of commitment to effective action and transparency.³⁰

In September 2005, North Korean authorities announced that it had enough food and ordered the WFP to end its humanitarian aid programme citing better harvests and domestic concerns about the emergence of a dependency culture and the intrusiveness of monitoring. Despite the WFP's assessment of North Korea's critical need for continued food aid, the government stated that only medium- and long-term (technical) development assistance would be permitted. However, international food aid through the WFP, which ended in December 2005, resumed a year later due to devastating floods in 2006 and 2007.³¹

North Korea has an obligation to accept international humanitarian assistance when it cannot meet the needs of its own people. But the North Korean government has refused some urgently needed humanitarian assistance on political grounds.³² For example, in May 2008, the US government resumed food aid to North Korea for the first time in three years. But due to strained relations in March 2009, North Korea refused to accept any further food aid from the US and told five US humanitarian aid organizations³³ to leave the country by the end of the month. In March 2010, the US government said it would consider resuming food aid to North Korea if the North retracted its refusal of humanitarian assistance.³⁴

As the largest provider of food, fuel and industrial machinery, China plays a key donor role to the North. Imports from China increased 46 per cent from US \$1,393 million in 2007 to US \$2,033 million in 2008.³⁵ Similarly in previous years, South Korea was one of the biggest donors of food, medicines and fertilizer. Under the Roh Moo-hyun administration, the government gave approximately 227 billion South Korean won (KRW, equivalent to US\$227,000,000) in humanitarian assistance in 2006 and KRW 198 billion (US\$209,000,000) in 2007. Under the current Lee Myung-bak administration, South Korea's humanitarian assistance was drastically reduced to about KRW 44 billion (US\$40,000,000) in 2008 and KRW 46 billion (US\$37,000,000) in 2009.³⁶

North Korea has not requested assistance from South Korea since President Lee Myung-bak took office in February 2008. Unlike his two predecessors, Lee has linked the provision of humanitarian assistance to progress on nuclear weapons negotiations.³⁷ During a slight improvement in relations between the two Koreas, the South made an aid offer in October 2009 of 10,000 tons of corn, 20 tons of powder milk and medicine to the North. South Korea's Ministry of Unification acknowledged that the aid was far less than needed, but

“there is no change in our position that massive food aid depends on how relations between the two Koreas develop.”³⁸ At the time of publication of this report, 125 items of medicine in February 2010 and 20 tons of milk powder a month later had left the South. No corn was sent.³⁹

2.4. GOVERNMENT POLICIES AGGRAVATING THE FOOD CRISIS

A North Korean government decree on 30 November 2009 announced currency revaluation at a rate of 100 to one, reportedly in an attempt to control unauthorized economic activity and stem inflation. There was a restriction placed on the amount and period in which old notes could be exchanged for new ones. In effect, these measures wiped out the bulk of many people’s savings, especially those who made a living trading and selling goods at *jang madang*, private or free markets.⁴⁰

Reports from North Korea indicated spiralling inflation, food shortages and public unrest. At the onset of the revaluation, US\$1 was valued at 98 North Korean won (KPW), but less than three months later, by February 2010, it had plummeted to KPW300-500. According to a February 2010 report by the UN Special Rapporteur on the Situation of Human Rights in the DPRK, the government also barred people from using foreign currency, closed down markets where produce was traded, and prohibited small-plot farming.⁴¹

Good Friends, a South Korean non-governmental organization with contacts in the North, reported that compared to prices before the currency revaluation, the cost of rice had more than doubled in December 2009 to KPW50 per kilogram. One kilogram of rice used to sell for KPW18-20,000 (thus, approximately KPW18-20 in the new currency).⁴² The aid group also reported that thousands of people had starved to death in South Pyongan province between mid-January and mid-February 2010.⁴³

Without access to these markets and with state stores displaying empty shelves, many people were forced to pay exorbitant prices for food from black marketers. Reportedly in response to growing social unrest due to the chaos created by the currency revaluation, North Korean authorities lifted the ban on free markets at the end of December 2009 and in 2010, allowed markets to operate more freely.⁴⁴

Between 2000 and 2004, the North Korean government allowed private or free markets where people could buy food, as well as engage in trade and retain their profits. This was a crucial lifeline for many people, as they could access food outside the PDS and earn a living. However from 2007 to 2008, North Korean authorities prohibited women under 40 years old from working at free markets (this age limit was later raised to 49), disproportionately hurting women who make up a significant percentage of market vendors.⁴⁵

According to FAO/WFP statistics, the cost of food in the markets “sky-rocketed” between June 2007 and June 2008. In Pyongyang, the price of rice increased 2.5 to three times and corn cost four times more. However, official salaries during this period remained stagnant and informal incomes suffered from government restrictions on market activities. These economic realities have severely impacted on the already restricted diet of North Korean households:

“While a traditional Korean diet consists of rice, vegetables, wild foods, soybeans, meat and oil, most families now consume mainly maize and a combination of vegetables and wild foods. Oil is used in very small amounts in only a few households,

while beans and other proteins are nearly absent from the diet. The quality of diet consumed by PDS-dependent households was found to be poorer now than during the 2004-2005 period."⁴⁶

Despite food shortages reaching critical levels, the government took measures in 2009 to prohibit the farming of kitchen gardens.⁴⁷ These small plots of land are an important source of food, especially during the lean season when food is scarce.⁴⁸

2.5. CONTINUED FOOD INSECURITY

In June 2008, the FAO and WFP jointly carried out a Rapid Food Security Assessment (RFSA) in 53 counties across eight provinces.⁴⁹ In the RFSA, the UN agencies identified groups and regions most vulnerable to food insecurity in North Korea:

- Socially vulnerable: children in state institutions, elderly people and children in paediatric wards;
- Physiologically vulnerable: pregnant and lactating women, children under 5 and adolescents;
- Geographically vulnerable:
 - The North-east: Ryanggang, North Hamgyong provinces; urban areas predominantly in counties with declined industrial activity;
 - In the South: counties affected by floods in recent years and South Hamgyong due to economic remoteness.⁵⁰

Province	Accessible Counties	All Counties
South Pyongan	1,719,000	1,910,000
Pyongyang	213,000	243,000
South Hamgyong	1,212,000	1,391,000
North Pyongan	1,064,000	1,165,000
South Hwanghae	963,000	1,062,000
North Hwanghae	891,000	960,000
North Hamgyong	894,000	983,000
Kangwon	440,000	500,000
Ryanggang	276,000	314,000
Chagang	182,000	206,000
Total	7,854,000	8,741,000

Figure 1: Estimated number of food insecure persons in North Korea by province, 2008/09 (FAO/WFP)

In a Crop and Food Supply Assessment Mission jointly also conducted by the FAO and WFP from 9-24 October 2008, almost nine million people out of a population of 23.7 million were estimated to be food insecure in North Korea (figure 1).⁵¹ In their assessments, the WFP/FAO confirmed significant deterioration in food security in 2008:

*"Close to three quarters of respondents had reduced their food intake, over half were reportedly eating only two meals per day (down from three) and dietary diversity was extremely poor among two thirds of the surveyed population. Most North Koreans sustain themselves by consuming only maize, vegetables and wild foods, a diet lacking protein, fats and micronutrients. Food is scarcest during the "lean season", the five-month period prior to the autumn rice and maize harvests when stocks of the previous year's crops rapidly run dry."*⁵²

2.6. COPING AND SURVIVING MECHANISMS

The ongoing food and economic crisis, compounded by the breakdown of the PDS followed by reduced and intermittent PDS rations, has forced North Korean households to develop coping and survival strategies. For instance, many North Koreans have supplemented their diet and earned much-needed cash through hillside farming, kitchen gardens and raising livestock.⁵³ During the lean season (the five-month period prior to the autumn rice and corn harvests) when food is scarcer, coping strategies include reducing food intake, eating less preferred foods, foraging for wild foods and receiving assistance from relatives.⁵⁴

In North Korea, family networks play a crucial role in accessing health care, as help is needed in getting to a hospital, procuring and paying for medicine, paying doctors, and/or being nursed during hospitalization. As such, people living alone, especially children (orphans, abandoned and street children) and the elderly, are clearly at a disadvantage. Yoo, a 21-year-old woman from North Hamgyong province, explains this challenge:

“When you’re alone, it’s more difficult to survive because you don’t have anyone to help you in times of need. So if you’re sick and need money for medicine, you just have to find some other way to get some, like borrow from your neighbours but that’s not always easy.”⁵⁵

Reduced government food rations through the PDS are also not enough to survive on even when the PDS is functioning. With suspended state salaries in many sectors, many North Koreans have to find private employment, such as operating a market stall, transporting goods to remote parts of the country, brewing alcohol, logging and trading with Chinese merchants.

Lee is a 39-year-old woman from Chongjin, North Hamgyong province. Her husband was a welder employed at a large iron factory. They had normally received food rations twice a month but since the food shortages in the 1990s, they received them only once a month and sometimes not at all. The amount for Lee’s family of three was also reduced from 700g to 450g per day. As the family could not survive on rations alone, they had to find other means of earning an income:

“We received 15kg of corn and 1 to 2kg of rice per month. To stretch our income, we made alcohol from the corn. We also ate the sediments from the corn alcohol. It was difficult to eat because of the bitter taste, but we were hungry and had to eat them. There was no choice. The leftover corn husks were used to feed pigs, which we also raised to earn extra cash. We earned about KPW2,400 per month. (In 2005-2006, 1kg of rice cost KPW800 and 1kg of corn cost KPW400).”⁵⁶

The Chinese government regards all undocumented North Koreans as illegal economic migrants and adheres to a policy of arrest and deportation. Despite these dangers, North Hamgyong province’s proximity to China offers a limited but essential lifeline to those living near the border,⁵⁷ as noted by Shin, a 20-year-old man from Hoeryong, North Hamgyong province who had left North Korea in December 2006:

“Compared to other parts of this province, we lived relatively well in Hoeryong. We were lucky because of our proximity to the Chinese border, which meant a lot of cross-border trade between the two countries.”⁵⁸

Na, a 21-year-old man from another border area, made a similar observation:

“People in Onsong [in North Hamgyong province] lived relatively well because in many households one or two parents worked in China. So the other parent or relatives would sell the Chinese goods at the market in North Korea and earn money. These families earned a good living. But if one or both of your parents are dead, then your ability to survive greatly diminishes, as you don’t have earning power. These families lived worse than we did.”⁵⁹

2.6.1. DIGESTIVE PROBLEMS

Many of the North Koreans interviewed by Amnesty International spoke of directly experiencing long-term and chronic malnutrition and spoke of relatives who had starved to death. All interviewees felt that their poor diet had an adverse effect on their health. The most common ailments were digestive problems, including stomach aches/cramps, vomiting, diarrhoea and heartburn.

Like many North Koreans who escaped to China, Kim, a 26-year-old woman from North Hamgyong province, went to China in 2002 because “food was scarce”. In North Korea, she normally ate one meal per day, consisting of watery corn gruel, and sometimes went without food.⁶⁰ North Koreans, like Kim who live hand-to-mouth, have very irregular diets. Depending on their earning capacity, they can go from not having anything to eat to consuming three full meals per day. As Tak, a 26-year-old man from Musan, North Hamgyong province, told Amnesty International:

“I ate whenever I had money to buy food. Often I would eat once a day or nothing at all. If I had money, I would eat two to three times a day, until I was full.”⁶¹

Bae, a 19-year-old man from Daedong, South Pyongan province, described the reason for and consequences of such a diet:

“Indigestion is very common in North Korea because our food consumption is really irregular. If business is bad, then you don’t eat for days. If business is good, then you gorge on food until you feel sick. After an eating binge, you are sick for three to four days where your stomach hurts and you have indigestion. Also during harvest or planting season, we go to the fields to work. So after a full day of farming, you return home dead tired. You only have energy enough to eat. Then you go immediately to sleep, which doesn’t help your digestion.”⁶²

Hwang, a 24-year-old man from Hwasung, North Hamgyong province who left North Korea in September 2001, was homeless and lived on his own for six years from the age of nine. His parents were divorced when he was very young and his mother went to China leaving him behind. He was one of the growing number of *kkotjebi*⁶³ or homeless children who had either lost their parents due to starvation or whose parents had abandoned them or went to China to find a job. According to Hwang, his irregular and sporadic meals brought on digestive problems:

“I normally ate one meal a day. I was always hungry. If I had something to eat, I would eat it all – even if I was full, I would still continue eating because I didn’t know when I would have the chance to eat again. Also because I was homeless, I couldn’t

*take the food with me, so I just finished it in one go. Whenever I ate too much, I suffered from indigestion, including stomach ache and diarrhoea.*⁶⁴

Na, a 21-year-old man from Onsong, North Hamgyong province, worked with his mother from the age of 8 to 12 years at the local coal mine. Since the early 2000s, he suffered from chronic digestive problems and tried to ameliorate his pain through self-medication by taking aspirin⁶⁵ at night. He recounted how intestinal or maw worms (*Ascaris lumbricoides*) “30cm in length” emerged from his mouth. Although Na took anti-worm medication, the worms continued to re-appear due to “poor hygiene”. According to him, the low level of hygiene was due to his work environment, coupled with living in close proximity to farm animals, open sewer and waste that was not properly disposed.⁶⁶

A 2010 report by South Korea’s Korea Centres for Disease Control and Prevention (KCDC) looked at medical exams of North Korean settlers who had arrived in South Korea in 2008. It revealed that nearly half of young North Koreans, aged between 13 and 18, were infected with parasites, such as maw worms. The overall rate of infection for that year was 29 per cent.⁶⁷

At times, the very poor in North Korea rely on “non-traditional” wild foods⁶⁸ to satiate their hunger. Although most interviewees knew that such foods were often poor in nutrition, they still consumed them in order to curb hunger. Quite often, grass or roots are added to existing foodstuff to “make food go further”. For example, grass is mixed with ground corn to make corn gruel. Hwang’s diet also consisted of wild foods and other sources that were equally poor in nutrition:

*“People don’t normally eat wild foods except when there’s nothing else. I ate several different kinds of wild foods, such as neung-jae, which is a wild grass found in the fields. It’s poisonous – your face swells up the next day. Other grass and some mushrooms are poisonous so you could die if you picked the wrong one. Sometimes I mixed corn powder with pine tree bark, which gave me digestive and bowel problems but I needed to add something to my food to satiate my hunger. I also ate the leftover ingredients after making corn alcohol and tofu. I knew all these foods had little nutritional value, but I still ate them to fill my stomach.”*⁶⁹

Park, a 27-year-old man from Chongjin, North Hamgyong province who left North Korea in April 2007, also had adverse reaction from eating wild foods:

*“I foraged for wild foods in the mountains. Once I almost died eating mushrooms that were poisonous. Some wild greens or roots can be dangerous or difficult to digest. Often I suffered from stomach ache or diarrhoea. During a particularly rough patch, I also ate food you normally feed to pigs.”*⁷⁰

3. SUSCEPTIBILITY TO ILLNESS AND DISEASE DUE TO FOOD INSECURITY

North Korea's long-term food insecurity is a major factor in serious, chronic health problems for millions of North Korean people. Poor or inadequate nutrition significantly weakens a body's ability to fight off illness. Malnutrition compromises people's immune system, increasing their vulnerability to infections and diseases. According to an article in the American Journal of Clinical Nutrition:

"Infections, no matter how mild, have adverse effects on nutritional status. The significance of these effects depends on the previous nutritional status of the individual, the nature and duration of the infection, and the diet during the recovery period. Conversely, almost any nutrient deficiency, if sufficiently severe, will impair resistance to infection. Iron deficiency and protein-energy malnutrition, both highly prevalent, have the greatest public health importance in this regard."⁷¹

North Korean law guarantees the right to health of vulnerable groups. For instance, article 11 of North Korea's Public Health Law outlines state obligation to provide "deep attention to the health protection of women and children". Moreover, article 13 obliges the state to take "responsible care" of the elderly, including their right "to receive free medical treatment".

Despite these provisions, decades of food shortages have taken a toll on the levels of health of vulnerable sectors of the population. The WFP has identified the elderly, pregnant and lactating women, and young children in North Korea as "particularly vulnerable to food insecurity and malnutrition due to their particular dietary needs".⁷²

Stunting reflects shortness-for-age; an indicator of chronic malnutrition and calculated by comparing the height-for-age of a child with a reference population of well nourished and healthy children.

Underweight is measured by comparing the weight-for-age of a child with a reference population of well nourished and healthy children. It is estimated that worldwide the deaths of 3.7 million children aged less than five are associated with the underweight status of the children themselves or their mothers.

Wasting reflects a recent and severe process that has led to substantial weight loss, usually associated with starvation and/or disease. Calculated by comparing weight-for-height of a child with a reference population of well nourished and healthy children. Often used to assess the severity of emergencies because it is strongly related to mortality.⁷³

According to a 2009 UN Children’s Fund (UNICEF) report, North Korea was one of 18 countries with the highest prevalence of stunting (moderate and severe) among children under 5 years old. Between 2003 and 2008, 45 per cent of North Korean children under five were stunted. For the same age group, nine per cent were suffering from wasting and 25 per cent were underweight, seven per cent severely.⁷⁴ Moreover in 2009, the WFP announced that in the DPRK, 37 per cent of children under five were malnourished and one third of women were malnourished and anaemic with poor dietary diversity.⁷⁵

According to the World Health Organization (WHO), vulnerability to ill-health can be reduced by taking steps to respect, protect and fulfil human rights”, such as the right to food and nutrition. In developing countries, poor nutrition contributes to 53 per cent of deaths associated with infectious diseases among children younger than five and one in three people are affected by vitamin and mineral deficiencies and therefore, more subject to infection, birth defects and impaired physical and psycho-intellectual development.⁷⁶ In the context of North Korea, the population has lived with long-term food insecurity and chronic malnutrition since the 1990s. Malnutrition weakens a person’s immune system increasing risk of infections and infectious diseases, and reducing chances of recovery.⁷⁷

3.1. TUBERCULOSIS EPIDEMIC

For over a decade, North Korea has been battling with a tuberculosis (TB) epidemic. The WHO attributed this “explosion” of TB cases to the “overall deterioration in health and nutrition status of the population as well as the rundown of the public health services”.⁷⁸

An estimated five per cent of the North Korean population, estimated at 23,790,000,⁷⁹ is infected with TB, although true figures may be much higher.⁸⁰ WHO statistics for 2007 (figure 2) revealed that approximately 15,000 deaths occurred due to the TB epidemic. In addition, there were a total of 105,000 cases of TB including approximately 82,000 new cases in 2007 or 344 newly infected per 100,000 per year. Four per cent of new cases were found to be multi-drug resistant (MDR)-TB (TB that is resistant to first-line anti-TB drugs), while 23 per cent of previously treated patients were also MDR-TB.⁸¹

Incidence	
All forms of TB (thousands of new cases per year)	82
All forms of TB (new cases per 100 000 population/year)	344
New sputum-smear positive (ss+) cases (thousands of new cases per year)	37
New ss+ cases (per 100 000 pop/year)	155
Prevalence	
All forms of TB (thousands of cases)	105
All forms of TB (cases per 100 000 population)	441
2015 target for prevalence (cases per 100 000 population)	421
Mortality	
All forms of TB (thousands of deaths per year)	15
All forms of TB (deaths per 100 000 population/year)	65
2015 target for mortality (deaths per 100 000 population/year)	57
Multi-drug resistant TB (MDR-TB)	
MDR-TB among all new TB cases (%)	3.9
MDR-TB among previously treated TB cases (%)	23

Figure 2: Estimates of epidemiological burden, 2007⁸² (WHO)

TB is an airborne infectious disease that is spread by inhaling infected droplets released into the air by an infected person through coughing, sneezing or just talking. Pulmonary TB is the most prevalent form of TB, but this disease can spread to other parts of the body, such as the bones or nervous system. Typical symptoms include a persistent cough, weight loss and night sweats.⁸³

According to the Eugene Bell Foundation, an international humanitarian organization focusing on TB, the government of North Korea had in place a very effective TB treatment system from the late 1960s to the mid-1970s. This included an aggressive campaign to combat the disease. As a result, the country made significant progress but “lost momentum” during the economic crisis of the 1990s when pharmaceutical and medical equipment factories shut down.⁸⁴

Chronic malnutrition has left many North Koreans with a compromised immune system and heightened their susceptibility to infections and diseases.⁸⁵ Malnutrition increases risk of infection and is generally regarded as a major risk factor in the onset of active TB.⁸⁶ The WHO has stated that:

“Undernutrition is a well-established risk factor for TB. It is clear that improved nutritional status at population level can have significant impact on TB morbidity and mortality.”⁸⁷

In 1998, North Korea implemented its “Plan of Action for the Implementation of DOTS [Directly Observed Treatment Short-Course],⁸⁸ 1998-2003”. With the help of the WHO, the government introduced the DOTS strategy to control TB and by 2003, the programme was implemented throughout the country.⁸⁹ However, interviews with North Koreans (cited later in this section) indicate that the government’s TB control programme faces many challenges at the implementation level.

According to media reports, TB wards run by the military discharge patients who have only partially recovered. Patients then return to their military units only to be re-admitted after relapsing.⁹⁰ If people infected with TB do not receive proper treatment, miss doses, fail to complete a course of treatment, or if their doctor gives them inappropriate treatment, they risk developing a resistance to the most effective first-line anti-TB drugs. Those who develop multi-drug resistant (MDR)-TB must take a supply of medicines specially formulated to tackle their body’s resistance. Such treatment is more difficult, often lengthier (up to two years or more) and costly.

In this context, public health education on TB and dissemination of information about its symptoms, preventative measures, treatment, as well as tackling social stigma become ever more crucial to containing the epidemic and preventing deaths. Several interviewees who had been infected with TB told Amnesty International that their illness was initially misdiagnosed as a “common cold”.

In 2008, North Korea sent doctors from the Ministry of Public Health to visit TB experts in the US. This led to a project initiated by scientists at Stanford University’s School of Medicine, which helped develop North Korea’s first laboratory capable of detecting drug-resistant TB. In February 2010, a team from Stanford installed the diagnostics laboratory at a hospital in Pyongyang. However, according to Sharon Perry, the epidemiologist leading the team, North Korea does not have the more expensive antibiotics that attack drug-resistant TB and will also run out of first-line antibiotics by July 2010 if the international community does not help.⁹¹

Kwon, a 47-year-old man from Yanggang province, was a researcher of health products such as vitamin tablets. Like others, his younger son who was infected with TB was misdiagnosed in 2007 with having a bad cold. Two months after the misdiagnosis, when the son's conditions deteriorated with high fever and severe cough, Kwon took him to a larger hospital:

"During the two months of incorrect diagnosis, we weren't treating the correct disease so my son became very sick and weak. At the second hospital, he underwent an x-ray and blood test. This time, I gave the doctor 10 packs of cigarettes hoping for better service. I asked the doctor to share them among his colleagues. He was diagnosed with TB, which is very common in North Korea. The doctor wrote down what medicines I should buy for my son. Hospitals in North Korea no longer have medicines. Medical personnel either don't receive any or if they do, they sell them in the markets."

The doctor informed Kwon that his son needed to follow a regimen of four different kinds of antibiotics according to the Directly Observed Treatment Short-Course (DOTS) for TB.⁹² These medicines were not supplied by the hospital so Kwon purchased them at the market. But after six months, his son was "still feverish and sick" so they returned to the hospital. Further diagnosis from a different doctor attributed the son's lack of improvement to the fact that the medication was taken after breakfast and not before. Without medical advice, Kwon decided to "allow my son's body to recover for about two to three months", before he purchased three more months' worth of medicines for him.⁹³

It is unlikely that the mealtime had much impact on his son's TB treatment and it is ill advisable to take a break from the treatment. In fact when Kwon's son arrived in South Korea in April 2010, he was hospitalized and had to undergo treatment for MDR-TB.⁹⁴

From 2001 to 2003, Park, a 27-year-old man from Chongjin, North Hamgyong province, suffered from TB of the lymph nodes. In December 2001, Park developed a small swelling on the left side of his neck and went to see a doctor at a small clinic:

"The doctor told me it was due to the cold weather. He told me to have penicillin injections once a day, which I did for about two months. But my condition didn't improve. The area around my neck grew, becoming increasingly swollen with pus."

In February 2002, another doctor diagnosed the swelling as TB of the lymph nodes and recommended surgery "to remove the tumour-like lump and the pus in the swollen area". As his family could not afford the cost of the surgery,⁹⁵ the doctor informed him that in the absence of surgery, Park needed to follow the DOTS six-drug regimen for six months. Despite the doctor's advice, he took the prescribed medication for two years (taking a break for one month after the initial six months):

"So without surgery, I just took the recommended medicines and had penicillin injections. In total, they were about six different kinds of medicine, both Chinese and South Korean. Our relatives in China bought them and sent them to us – you have to be careful in North Korea because many counterfeit medicines are sold at markets. These medicines can ruin your liver, so I took other medicines to help the liver."

Park's inflammation eventually burst and spread to two other areas. Without medical advice, he stopped taking his medication when the third burst "healed".⁹⁶

3.2. ANAEMIA AMONG WOMEN

Anaemia is “a condition in which the number of red blood cells or their oxygen-carrying capacity is insufficient to meet physiologic needs, which vary by age, sex, altitude, smoking, and pregnancy status”.⁹⁷ In poor countries, such as North Korea, iron deficiency is the most common cause of anaemia.⁹⁸ Women are particularly vulnerable because they are more likely to have iron-deficiency anaemia during heavy menstrual periods or pregnancy.⁹⁹ Higher levels of anaemia subjects women to greater vulnerability during pregnancy and child birth. Acute anaemia in some countries is also a big contributor to maternal mortality.¹⁰⁰

The WHO measures anaemia through the concentration of haemoglobin in blood (g/L) with a threshold for non-pregnant women at 120 g/L. In 2004, the WHO conducted a survey of 1,253 women from the capital of Pyongyang and seven provinces.¹⁰¹ On average, it found that 35 per cent were below 120 g/L with the highest concentration of 61 per cent in South Pyongan province. In 1998, the WHO conducted a similar survey of 72 pregnant women and found 35 per cent were below the 110 g/L threshold for pregnant women. Moreover, according to a study conducted by South Korea’s Korea Centres for Disease Control and Prevention (KCDC), a quarter of North Korean women over 18 years who had arrived in South Korea between 2005 and 2008 were anaemic.¹⁰²

Sohn, a 23-year-old woman from Saetbyul, North Hamgyong province, suffered from chronic nosebleeds and dizzy spells when growing up in North Korea. She was diagnosed with anaemia in 2007 when she was living in China:

“When I was growing up in North Korea, I remember getting blood on my pillow because my nose would bleed when I was sleeping. This happened about two to three times per week. I also got dizzy spells when walking or studying at school. My condition improved drastically once I moved to China probably because I was eating better. My anaemia temporarily returned when I was stressed due to starting a job at a restaurant. Since my arrival in South Korea in March 2008, I only had a nosebleed once.”¹⁰³

Lim is a 19-year-old woman from Hoeryong, North Hamgyong province who had left North Korea in April 2009. She suffered from anaemia, although her condition was never diagnosed by a doctor:

“Since 1997 when I was in 4th grade of primary school, I was anaemic. I had dizzy spells whenever I stood up. Sometimes I couldn’t see and everything would go black for a few minutes. I haven’t been diagnosed but other people told me it was anaemia. So that’s when I realized that I had it.”¹⁰⁴

4. INSUFFICIENT GOVERNMENT SUPPORT FOR THE HEALTH CARE SYSTEM

“Medical personnel shall be kind to patients and treat them with warmth and wisdom.”

Article 42 of North Korea’s Public Health Law

The North Korean government has failed to adequately address the country’s ongoing food shortages since the 1990s. This failure has led to the current critical situation in which the population faces severe health problems associated with malnutrition. Compounding these problems, North Korea’s government has failed to provide adequate resources for its health care system, which as a result is wholly unable to cope with the growing number of illnesses and diseases of a population weakened by hunger. According to the WHO, North Korea spent less than US \$1 per person in 2006. In fact, North Korea had one of the lowest recorded per capita total expenditure on health in 2006 of any country in the world.¹⁰⁵ The state’s paltry expenditure on health, in spite of the urgent need for medical training, access to medicines and public health education, violates North Korea’s obligation to provide for the basic health of its population.

According to witnesses, many health facilities are decades old and suffer from a lack of upkeep and maintenance. Witnesses described health facilities as generally unheated, without running water and subject to frequent power cuts due to energy shortages. Doctors, who often work without pay, have little or no medicine to dispense and must re-use what scant medical supplies they have at their disposal. They perform their duties often with only the aid of daylight and sometimes by candlelight. During operations, patients, if lucky, are given anaesthesia but sometimes not enough to completely control the pain.

Several witnesses also described a lack of basic hygiene in many health facilities. As health workers struggle to maintain the hygiene level, patients must cope with unsanitary conditions in operating theatres and hospital wards. Min, a 22-year-old woman from Hyesan, Yanggang province, described one facility where she nursed her hospitalized brother in 2005:

“It’s really up to family members of patients who take turns cleaning, taking out the rubbish and watering down the ward. There are blood stains still on bed sheets – even after nurses have washed them. Usually the sheets are changed only once when a new patient is admitted. In my brother’s case, his sheets were changed three or four times in three months only because he had asked the nurses.”¹⁰⁶

Under the management of the Ministry of Public Health, North Korea has an extensive network of more than 800 general and specialized hospitals at the central, provincial and country levels. In addition, there are about 1,000 hospitals and polyclinics at *ri* and *dong*¹⁰⁷ employing approximately 300,000 medical professionals. The Ministry of Public Health also manages nurseries and pharmaceutical industries.¹⁰⁸

In North Korea, a household doctor (family doctor) provides the health care of around 130 to 140 households, as stated by North Korea in its 2009 national report for the Universal Periodic Review (UPR) at the Human Rights Council:

*“Household-doctor system has a large share in the primary health care system. 44,760 doctors at about 7,000 polyclinics, ri-people’s hospitals and clinics are responsibly taking care of people’s health at a ratio of one doctor per an average of 134 households.”*¹⁰⁹

This system includes all aspects of health promotion, as well as illness prevention, cure and rehabilitation.¹¹⁰

In the 1999 national health development programme for 2000-2005, the Ministry of Public Health outlined its main goal to rehabilitate its health care system, including health facilities, so that medical professionals can provide the level of health care prevailing before the 1990s.¹¹¹

In November 2001, Dr Gro Harlem Brundtland, the then Director-General of the WHO, visited North Korea and declared that its health care system was in a state of “near collapse”, lacking essential medicines and equipment, running water and electricity. She stated that funds were urgently needed to avoid a major health crisis and that “there needs to be a higher priority given to the health sector”. In 2001, North Korea spent three per cent of its Gross Domestic Product (GDP) on health expenditures¹¹² or 5.9 per cent of its national budget, compared to 7.6 per cent in 1990 and 8.4 per cent in 1985.¹¹³

Following her trip to North Korea in April 2010, Margaret Chan, Director-General of the WHO, acknowledged achievements made in health care, such as 90 per cent childhood immunization coverage and success in controlling a resurgence of malaria, but said the state could do more:

*“The health system requires further strengthening to sustain universal coverage and to improve the quality of services. More investments are required to upgrade infrastructure and equipment, to ensure adequate supplies of medicines and other commodities, and to address the correct skill mix of the health workforce.”*¹¹⁴

Country/Region	2006 ¹¹⁵
Bhutan	49
Myanmar	5
Nepal	17
North Korea	0.50
Timor-Leste	52
SE Asia	31
Global	716

Figure 3: Per capita total expenditure on health at average exchange rate (US\$) (WHO)

Latest available figures for North Korea from the WHO (figure 3) show that the country’s per

capita total expenditure on health in 2006 was dramatically lower than four other countries in South-east Asia that had either the same (Myanmar) per capita GDP or lower (Bhutan, Nepal and Timor-Leste).¹¹⁶ (WHO's South-East Asia region includes Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, North Korea, Sri Lanka, Thailand and Timor-Leste.)¹¹⁷

In 2003, WHO findings on the health needs of the DPRK¹¹⁸ reported that the knowledge and skills of North Korean health workers were low by international standards. Due to resource scarcities and "little exposure to new developments in international best practice", medical education also suffered. In order to fill this knowledge gap, WHO's strategy for 2004-2008 prioritized investment in re-training of health workers in line with international norms and standards.¹¹⁹

In line with the WHO assessment, the overwhelming majority of interviews with North Koreans in their 30s or older told Amnesty International that health care and health care facilities had deteriorated significantly since the food and economic crisis of the 1990s. They did not notice any notable improvements in the 2000s. The interviewees also pointed out that medical care and health facilities were much better in the 1980s.

4.1. UNOFFICIAL PAYMENTS

In its second periodic report to the CESCR in May 2002, the North Korean government maintained that under article 9 of the Public Health Law, all citizens enjoyed free medical care specifying that:

*"Every medical service is free including all medicine supplied to patients, diagnosis, tests, treatment, operations, sick calls, hospitalization, medical check ups, consultations, vaccinations, midwifery, blood transfusions, dental prostheses, etc."*¹²⁰

Similarly in its 2009 national report for the Universal Periodic Review (UPR) at the Human Rights Council, North Korea asserted that:

*"Complete and universal free medical care has been provided since February 1960, which was later legalized by the Constitution and the Public Health Law. Everyone in the DPRK receives medical service of all categories equally, practically and free of charge."*¹²¹

Despite these assertions, interviews with North Koreans indicate that medical care has not been free since the 1990s. In fact, their reality paints a very different picture of the health care system in North Korea.

The majority of interviewees stated that they or their family members paid unofficial and illegal in-kind goods or sums of money to health workers, mostly doctors, while seeking medical care. In-kind payments such as cigarettes and alcohol were preferred by staff, as they were safer – doctors caught accepting money risked arrest and imprisonment – and could easily be sold for cash at free markets. Other patients also provided cooked food for medical personnel as a form of payment. Several interviewees recognized that health workers were often not paid and thus, needed to be recompensed for their services in order to survive.

Unofficial payments were especially prevalent for technical medical service, such as surgery or treatment that entails further tests, x-rays or hospitalization. As Heo, a 28-year-old woman from Hoeryong, North Hamgyong province who had left North Korea in January 2006, explained:

“If you need surgery, you need to give something to the doctor. Doctors earn money by performing operations. They can sell the cigarettes, clothes, etc. they receive from patients and their families. They can also earn money by providing medical certificates for work.”¹²²

Rhee, a 20-year-old woman from Chongjin, North Hamgyong province, left North Korea in November 2008. She noted similarly that:

“People in North Korea don’t bother going to the hospital if they don’t have money because everyone knows that you have to pay for service and treatment. If you don’t have money, you die. People without money just have to hope that they don’t get sick or can get better on their own. Doctors will not treat patients without compensation, especially for surgery. Nothing is free anymore.”¹²³

This was confirmed by Tak, a 26-year-old man from Musan, North Hamgyong province, who was homeless and forced to sleep in an abandoned warehouse for three months (December 2000 to February 2001). Due to pain in his hands and feet, he sought medical assistance but was denied access twice:

“During that winter, I got frostbite in both hands and feet. In March 2001, I was in so much pain so I went to a clinic attached to a factory, but they turned me away because I was not an employee. I then went to the local hospital. The doctor checked the frostbitten areas and told me that the frostbite needed to be treated urgently. Otherwise, they would have to amputate my limbs. He told me to buy penicillin and herb-based ointment. I didn’t have any money and he wouldn’t provide the medicine for free so I couldn’t be treated. All I could do was to protect my feet by wrapping them in cloth and wear thick military boots.”¹²⁴

Joo, a 25-year-old woman from Hoeryong, North Hamgyong province, told Amnesty International that her mother suffered from gall bladder infection in 2001, but was denied treatment:

“She needed surgery, but we didn’t have money to pay the doctor so he wouldn’t operate. There was nothing we could do but just put her on glucose drip at the hospital and at home for about one to two months. For surgeries in North Korea, you need to pay the doctor. Without money, you can’t survive.”¹²⁵

Hong, a 19-year-old man from Pyongyang, contracted pneumonia twice.

In 2000 when I was nine years old, I contracted pneumonia. I had chest pains and coughed a lot. At first, I just took aspirin that we had in the house, but when the chest pains continued, my mother took me to a small local clinic for penicillin injections, but they advised me to go to the main hospital.

At the hospital, the doctor examined me with a stethoscope and told me that I had pneumonia. I was supposed to take an x-ray but only big hospitals have these machines. Plus, we needed to pay for them so I couldn’t get it done. My mother gave the doctor a bottle of alcohol for his service. In North Korea, if you don’t

have any money, you will not receive proper medical care. Doctors and nurses treat you better once you give them a bottle of alcohol or cigarettes.

My condition became worse because I wasn't given any medication. The doctor told my mother that the hospital had medicines but I could only access them if I were hospitalized. So my mother asked a friend who was a doctor to help me get admitted.

During the two weeks of hospitalization, I was given antibiotics. Although I was still sick with cough and chest pains, the doctor discharged me so I recovered at home for another week.

In 2006, after I had arrived in South Korea, I was diagnosed with pneumonia again. The South Korean doctor took his time to explain how I could have contracted the disease and what my treatment was. From this experience, I truly felt the difference between doctors in the North and South.¹²⁶

4.2.ACCESS TO MEDICINES

Officially in North Korea, medicines cannot be purchased in pharmacies, but rather are supposed to be provided for free through state-run hospitals and clinics. The country's universal health care is supposed to provide patients with access to free medicines prescribed to them by their doctors. However, due to a chronic shortage of medicines and supplies at all levels,¹²⁷ hospitals rarely have medicines in stock and if available, patients normally need to pay for them, including antibiotics and anaesthesia. Most interviewees accept as "common knowledge" that health workers sell hospital medicines privately or to market vendors. Several have added that "doctors need to survive as well", referring to the reality that many health workers do not receive wages or rations and therefore, need to find a means to earn an income.

For many North Koreans, the main function of hospitals is to dispense medicines. There is limited understanding of the purpose of health care facilities and the importance of medical diagnosis. For North Koreans like Kim, a 26-year-old woman from North Hamgyong province who left North Korea in December 2002, hospitals and medical staff ceased to have a purpose once medicines were no longer free and/or available:

"It's no use going to hospitals because they don't have any medicines. It's better to buy medication at markets or directly from Chinese merchants. North Korean doctors aren't very good – the vendors are more knowledgeable about medicine and illnesses. They inform you which medicine you need to take and how much of it."¹²⁸

Without essential medicines, health facilities in North Korea clearly cannot provide services such as surgery without endangering the lives of their patients. Song, a 56-year-old woman from Musan, North Hamgyong province, told Amnesty International that she had to undergo surgery to remove her appendix in 2001 without anaesthesia because the hospital had none available:

"The operation took about an hour and ten minutes. I was screaming so much from the pain, I thought I was going to die. They had tied my hands and legs to prevent me from moving. I was hospitalised for one week and then I recovered for about a month at home."¹²⁹

Similarly in 2000, Hwang, a 24-year-old man from Hwasung, North Hamgyong province, had his left ankle crushed by a moving train when he fell from one of the carriages. Without any anaesthesia, his doctor amputated part of his left leg from the calf down:

“Five medical assistants held my arms and legs down to keep me from moving. I was in so much pain that I screamed and eventually fainted from the pain. I woke up one week later in a hospital bed.”¹³⁰

Hwang added that many other homeless children suffered accidents resulting in amputated limbs, a hazard he attributes to living outdoors and being physically weak due to malnutrition.

Chun, a 19-year-old man from Yanggang province, cut his upper right thigh in 2007 when he was swimming in the Tumen River. He was taken to a clinic where the doctor put five stitches in his leg also without anaesthesia. According to Chun, the townspeople held his arms, legs and head down so that he would remain still during the procedure.¹³¹

Interviews indicated that, even if patients receive a medical diagnosis, they or a family member must first buy the recommended medicine at a market or private home – sometimes of former health professionals. If it is an injection, then the drug is brought back to the hospital for the doctor to administer. When asked why there were no medicines available at hospitals, most interviewees explained that the medical staff sold them at markets, as many do not earn enough to survive. Some added that medicine vendors were often former medical personnel. Song, who had left North Korea in October 2003, described how the system worked:

“Even if North Koreans don't have money, they still go to hospitals hoping for help and diagnosis. At the hospital, a doctor diagnoses your illness and then tells you what medicine you need to buy at the market. Hospitals no longer stock medicines because doctors sell them to survive. There are also many former doctors or nurses who work at markets selling medicine because they make more money doing that than working at a hospital. They need to survive as well. So these vendors have medical knowledge.”¹³²

In rare cases where hospital pharmacies carry medicines – usually at cost – they are either domestically produced or provided by the UN. Most medicines sold at markets are from China. Medicines from South Korea, which are generally more expensive, are hidden and not openly sold. Interviewees told Amnesty International that they were illegal and the police would confiscate them on sight.¹³³ A few interviewees added that counterfeit drugs were widely circulated at markets so to be safe, they bought medicines directly from doctors.

4.3. MEDICAL EQUIPMENT AND SUPPLIES

Most of the North Koreans interviewed by Amnesty International described health facilities that functioned without adequate medical equipment and supplies, and health workers recycled medical supplies until worn, sometimes with little regard to hygiene and safety. Witnesses described how doctors and nurses re-used needles, which over time were severely dulled due to overuse and little attempt was made to properly sterilise them. Um, a 21-year-old woman from Chongjin, North Hamgyong province, received an injection at a hospital in 2004: “The doctor took a used syringe and dipped the needle in boiling water for about ten seconds before giving me my injection.”¹³⁴

Hong, a 19-year-old man from Pyongyang who left North Korea in March 2004, often went to a small clinic near his house for penicillin injections, which he felt he needed whenever he had a bad cold or fever. He described how the doctor administered the injection:

*"He just took a used syringe and gave me the penicillin injection. He didn't bother sterilizing it before he used it on me or afterwards when he used it on another patient. I only realized how unhygienic hospitals in North Korea were since coming to South Korea. For us, this level of hygiene was normal."*¹³⁵

By and large, few hospitals are equipped with x-ray machines. Normally, larger hospitals in major cities, such as the capital Pyongyang, have access to them. In other parts of the country and in smaller health facilities, the more commonly available x-ray device is a direct fluoroscopy machine. It is a poor and antiquated substitute that can endanger the lives of doctors who treat TB patients, as expressed by Dr Linton, Chairman of the Eugene Bell Foundation:

*"North Koreans are diagnosed with tuberculosis with a process called direct fluoroscopy, which means that the patient is placed between the doctor and a radiation source and in a dim room. The radiation is then shot through the patient into a fluoroscopy screen in front of the doctor's face."*¹³⁶

In order to view a patient's lung in real time using direct fluoroscopy, doctors knowingly expose themselves to the machines' potentially fatal doses of radiation, sometimes risking their own lives to help patients. At a hospital situated in the north-western part of North Korea visited by the Eugene Bell Foundation in 2008, three doctors died from diseases found to be related to radiation or exposure to patients' illnesses over the years – one from radiation poisoning, another from cancer and a third from TB.¹³⁷

Although Eugene Bell Foundation's main purpose in North Korea is to provide treatment for MDR-TB patients, it cannot do its work without addressing other health care needs. The Foundation has donated equipment from x-ray machines, operating tables, electrocardiograms, oxygen tanks, wheelchairs, stethoscopes and medical textbooks to bicycles and even plastic sheeting for greenhouses.¹³⁸

Tak, a 26-year-old man from North Hamgyong province who left North Korea in December 2006, speaks of his hardship in North Korea.

Since rations were cut in 1994 – the year that Kim Il-sung passed away – things became really bad for all of us in North Korea. My mother, who was blind and didn't work, died of starvation in 1997. My father was a repairman. He didn't get paid so soon after my mother's death, he went to China to find work. In 2004, he was arrested and forcibly repatriated. I don't know which detention centre he was sent to. That was the last I heard from him. I have an older sister (27 years old) and a younger brother (23 years old), both of whom I lost contact with since 1998.

My diet in North Korea varied a lot, depending entirely on the availability of food. I ate whenever I had money to buy food. Often I would eat once a day or nothing at all. If I had money, I would eat two to three times a day, until I was full.

Our family home was an old wooden house, which collapsed in December 2000 due to lack of maintenance. So I became homeless at the age of 16 and was forced to sleep in a warehouse with no heating for three months. I had no blankets, only a coat, so I stayed warm by burning wood. During that winter, I got frostbite

in both hands and feet.¹³⁹

In 2002, I had cold-like symptoms but didn't go see a doctor. A week later when I was in China, I went to a local hospital where I was diagnosed with pneumonia. I had to undergo treatment for 45 days. I was hospitalised for two weeks. I frequently travelled to China – in total, I went there 15 times and was arrested and forcibly repatriated eight times.

In North Korean markets, there aren't many domestically produced medicines. Most of the brands are Chinese. Others are Russian. South Korean medicines are hidden and not sold openly – the police would confiscate any South Korean products.

North Koreans normally do not go to the hospital unless they need surgery or they're really sick. Hospitals don't carry any medicine – even if you want an injection, you have to first buy the medicine at the market and bring it back to the hospital for the doctor to administer the drug. Only those with money go to the hospital like party members or government officials. If you don't have money, the government does not provide anything for you – unlike before, according to my parents. Nothing is free anymore.¹⁴⁰

4.4. ABUSE OF MEDICATION, INCLUDING NARCOTIC PAINKILLERS

Chinese merchants bring medicines across the border to sell directly to customers or market vendors. Doctors and other medical staff also sell drugs stolen from their workplace. Consequently, medicinal drugs are widely available at markets and in vendors' homes. These include highly addictive drugs, such as morphine and methamphetamine, the use of which in many countries would be strictly controlled and monitored. One painkiller particularly prone to abuse is *jeong tong pyeon*, an addictive anti-inflammatory painkiller and an opium derivative¹⁴¹ produced in China. *Jeong tong pyeon* is widely available in North Korea and relatively inexpensive.

Min, a 22-year-old woman from Hyesan, Yanggang province, nursed her older brother in August 2005 following his car accident, which resulted in the amputation of his left leg from above the knee. He was hospitalized for three months and spent another three months recovering at home. Although under the supervision of a doctor, her brother was taking morphine for an extended period of time:

“Upon advice from a nurse, I bought morphine at one of the houses near the hospital that functioned like a pharmacy. The medical staff then administered the injections - my brother needed one or two bottles per day for about six months. It was very expensive so he tried to withstand the pain and only took it when it was too much.”

According to Min, her brother exhibited withdrawal symptoms from the morphine, including shakes and diarrhoea. “Running out of money” was the principal reason given for discontinuing the drug.¹⁴²

In December 2009, the North Korean Ministry of Public Health issued a nationwide order prohibiting the use of *jeong tong pyeon*, which was prompted by a series of deaths (exact number unknown) where patients with H1N1 influenza in South Pyongan province were misdiagnosed with having a common cold. After taking the prescribed *jeong tong pyeon* and aspirin, their conditions deteriorated with high fever and they eventually died.¹⁴³ This is consistent with testimonies of several North Koreans who had left the North since late 2007.

They told Amnesty International that *jeong tong pyeon* was less popular due to illnesses and even deaths attributed to its use.

A 2009 survey by the Hanawon settlement centre¹⁴⁴ in South Korea indicated that the most widely used medicines among North Korean settlers prior to their arrival in the South were narcotic painkillers. The most common painkiller was *jeong tong pyeon*, which one in five people had taken.¹⁴⁵ One interviewee described it as a “cure-all”.¹⁴⁶ In fact, those interviewed for this report took it for a wide range of different health problems, including stomach ache, diarrhoea, headache, fever, cold, sore throat, joint or muscle pain and measles. Tak, a 26-year-old man from Musan, North Hamgyong province, bought *jeong tong pyeon* in March 2001 when he suffered from frostbite in both hands and legs:

“In order to buy the medicine that I needed, I found work logging in the mountains. I bought penicillin and jeong tong pyeon, the latter of which I pulverised and put directly on the wounds of the frostbitten area.”¹⁴⁷

Joo is a 25-year-old woman from Hoeryong, North Hamgyong province who left North Korea in August 2004. She took *jeong tong pyeon* for her frequent headaches. She explained the drug’s addictive qualities:

“Jeong tong pyeon is very effective but if you take it often, you’ll develop a dependency or immunity to the medicine so then you have to increase the dosage. My mother, who suffered from chronic headaches, took one to three tablets almost everyday for at least five years. She was dependent on them and didn’t feel good unless she took them.”¹⁴⁸

Lim, a 19-year-old woman from Hoeryong, North Hamgyong province who left North Korea in April 2009, also took *jeong tong pyeon* regularly for colds or fever. She estimated taking five to six tablets per month. According to Lim, both her grandparents took two tablets daily for their headaches, which otherwise would return.¹⁴⁹

Dr Kim Chul-han, a public health doctor who works with North Korean settlers in South Korea, is concerned about the excessive use of narcotic painkillers among many North Koreans as the “effects of the medicine will wear off, which could lead to a vicious cycle” where North Koreans require more painkillers and a stronger dose in order to feel their effects. He also attributes the high number of digestive problems among North Korean settlers to the use of *jeong tong pyeon*.¹⁵⁰

The 2009 Hanawon survey also indicated that 11 per cent of men and three per cent of women had taken *bingdu*, a Chinese medicine containing methamphetamine, for headaches and digestive problems. Lee Seung-yong, Director of Good Friends, explained that “In North Korea, basic medicine is wholly insufficient, so people use *bingdu* for headaches and enteritis symptoms [inflammation of the small intestine caused by a bacterial or viral infection]” and that “bingdu is considered basic medicine rather than a narcotic drug”.¹⁵¹

One interview, Sun, a 24-year-old woman from Hoeryong, North Hamgyong province, told Amnesty International that she, in common with other North Koreans, used a potent illegal and highly addictive drug in 2003 as a remedy for a common cold:

“Opium is illegal in North Korea but some families keep some at home for medicinal purposes. Once for a cold, I took an amount the size of my pinkie nail and melted it in hot water and drank it. I took it about five times, which must have been too much because I got high and slept for two days. As my body was numb, I couldn’t feel my

*back burning from sleeping on a hot ondo¹⁵² floor. This experience scared me so much that I never took it again.*¹⁵³

4.5. PHYSICAL ACCESS TO HEALTH CARE

Another obstacle to accessing health care in North Korea is the physical access to the facilities, as they can often be located far from people's homes. In its report to the CESC in 2002, North Korea stated that "[t]he State pays even the travel costs to and from the sanatorium, not to speak of the recuperation fee"¹⁵⁴. Contrary to the government's claim, the overwhelming majority of North Korean interviewees told Amnesty International that the government does not pay or reimburse patients for their travel costs nor does it provide accessible ambulance service for the public.

Large health facilities in urban areas are equipped with ambulances but due to a shortage of fuel supplies, they are rarely used. The lack of a mass telecommunication system also undermines their utility as an emergency response. Park, a 27-year-old man from Chongjin, North Hamgyong province, explained that:

"Since 1992 or 1993, I have not seen any ambulances circulating in my city. I've only seen them in television programmes. In theory, every big hospital, like a city or provincial hospital, has one or two ambulances. But in reality, they cannot be used because of the lack of petrol in the country. Plus, only the very rich have a phone in their house, so normal people like us cannot call for an ambulance. I think even if you called, nothing would happen because the vehicle wouldn't have any petrol. If there was petrol, the medical staff wouldn't use it for transporting patients. They would probably use it for other more profitable purposes."

According to Park, people who are ill and need to go to a hospital have three options. They can walk, pay for transport via cart or have a relative or friend carry them.¹⁵⁵

Min, a 22-year-old woman from Hyesan, Yanggang province, left North Korea in October 2007. She echoed Park's observations:

*"I know that North Korea has ambulances but I have never seen one on the streets. I don't know how to call for one or how accessible they are. In reality, if you have to go to the hospital, you need to walk or someone has to carry you on their back."*¹⁵⁶

Roh, a 21-year-old woman also from Yanggang province who left North Korea in November 2009, told Amnesty International that:

*"In 2006 and 2007, I have seen an ambulance circulating on the streets about three or four times a year, but I wouldn't know how to call one. There may be an emergency service number like 119 in South Korea, but I don't know what the number is. When I had to go to the hospital to get my appendix removed in October 2008, I went to the hospital by foot. It took about ten minutes – I was in a lot of pain, but I managed. If you are really sick, you can arrange for a private car to take you to the hospital, but of course you have to pay for it."*¹⁵⁷

In many parts of the country, especially in rural areas or poorer provinces in the north-east of the country, there is no reliable and affordable transport network. Owning a bicycle is a relative luxury and very few can afford private transportation. So without private transport

and in the absence of a functioning public transport system, the only means available to most North Koreans is travelling by foot. However, the long distances to health care facilities for many people make accessing health care very difficult.

In 2007, Kwon, a 47-year-old man from Yanggang province, took his son who had contracted TB to the hospital. The journey, on foot, took one and a half to two hours.¹⁵⁸ In 2002, Heo, a 28-year-old woman from Hoeryong, North Hamgyong province, had a bone fracture in her right leg. Because she was unable to walk, her mother took her by cart to the hospital.¹⁵⁹ In 2001, the mother of Joo, a 25-year-old woman also from Hoeryong, suffered from gallbladder infection. Unable to walk and not possessing any mode of transport, Joo's father had to carry his wife on his back to the hospital.¹⁶⁰

Travelling by foot may not be an option for those who are alone and too weak, ill or in too much pain to walk for an extended period of time. For example, Choi, a 20-year-old man from Chongjin, North Hamgyong province, dislocated his left ankle in May 2007 when he fell from the second floor of his house:

"I didn't go to the hospital because I couldn't walk and didn't have anyone to take me there. I only lived with my grandmother who was too old and weak to help me. I also didn't have any money to buy something for the doctor. So instead, I spent two months at home where I administered hydrotherapy on my ankle four times per day. I also applied honey to my ankle. It never healed properly and still hurts today when I walk for a long time."¹⁶¹

Transportation is a major challenge for pregnant women and one of the main reasons given by several female interviewees for the prevalence of home births in North Korea. Lee, a 39-year-old woman from Chongjin, North Hamgyong province, explained why, faced with several difficulties, giving birth at home in August 2002 was the only option available to her:

"When you're pregnant, you can't ride a bicycle and there are very few motorbikes or cars in North Korea. It would have taken me two hours on foot to reach the nearest hospital, which clearly was not possible for a woman in my condition."¹⁶²

In other cases, many North Koreans simply cannot go to hospitals due to the sheer distances involved. Han, a 23-year-old woman who lived in a village in North Hamgyong province, left North Korea in December 2005. According to her, she only went to see a doctor for serious illnesses because the nearest hospital was two to three hours away on foot.¹⁶³ The distance to medical facilities and a lack of accessible transportation can lead to delays in women accessing life-saving care, which often result in preventable mortality and morbidity.¹⁶⁴

As state party to the CEDAW, North Korea is obliged to ensure access for women to adequate health care facilities, including information, counselling and services in family planning.¹⁶⁵ Both the CESCR and the CEDAW Committee have clarified that the realization of women's right to health requires the removal of all barriers interfering with access to health services.¹⁶⁶ The CEDAW Committee has stated that "barriers include... distance from health facilities and absence of convenient and affordable public transport."¹⁶⁷

The CESCR has also emphasized that states are under a core obligation to ensure the equitable distribution of all health facilities, goods and services, and also the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups.¹⁶⁸ The government is therefore under a duty to prioritize those groups who face the greatest barriers realizing their rights when allocating resources.

In North Korea, medical facilities are generally better in the capital Pyongyang and larger cities. In theory, individuals who cannot access medical treatment in their place of residence can travel to another place where such treatment is available. However, travel within the country is restricted and North Korean law requires that citizens obtain a “traveller's certificate”. In its 2000 state report to the Human Rights Committee under the International Covenant on Civil and Political Rights, North Korea stated that:

“The DPRK citizens are free to travel to any place of the country on official or personal business subject to the Regulation of Travel. By article 4 of the Regulation the area along the Military Demarcation Line, military base, district of munitions industry and the districts associated with State security are travel restrictive. By article 6 of the Regulation the citizens who want to travel are issued with traveller's certificate. The certificate is issued by people's committees of all levels and there is no restriction.”¹⁶⁹

However, according to Ahn, a 22-year-old woman from Yanggang province who left North Korea in November 2008, obtaining permission to travel is not a transparent process:

“Pyongyang University hospital has better machines and is cleaner. It also provides food for its patients. If you're really sick and need more specialized care, then you can go to this hospital. But first you need travel permission and in order to get this, you need to give a bribe like cigarettes to the officials who work at the office where travel certificates are processed.”¹⁷⁰

5. RIGHT TO HEALTH: LEGAL FRAMEWORK

“Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes ... or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable.”

CESCR, General Comment 14, paragraph 1

5.1. INTERNATIONAL AND DOMESTIC LAW

North Korea has ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR); the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); and the Convention on the Rights of the Child (CRC). These treaties all protect the right to health and, as state party, North Korea is obligated to protect the rights of its population to the highest attainable standard of health.

Article 12 of the ICESCR obliges states parties to “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” and outlines the necessary steps “to achieve the full realization of this right” for:

“(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness”

Acknowledging resource constraints, the Covenant provides for progressive realization of several rights, including the rights to health and food. However, various core obligations of states parties take immediate effect such as, on the right to food, states must “...ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone”.¹⁷¹ On the right to health, states must ensure it is exercised without discrimination and take deliberate, concrete and targeted steps towards the full realization of article 12. The progressive realization of the right to health over a period of time is to be interpreted as “a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12”.¹⁷²

The right to the highest attainable standard of health is understood to mean health care and the underlying determinants of health, “such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment”.¹⁷³

Regarding domestic law, article 8 of North Korea’s Constitution (adopted in 1972 and revised in April 2009)¹⁷⁴ provides for human rights of its citizens, stipulating that:

“The state shall safeguard the interests of, and respect and protect the human rights of the working people, including workers, farmers, soldiers, and working intellectuals, who have been freed from exploitation and oppression and have become the masters of the state and society.”

Both the Public Health Law (adopted in April 1980 and revised in February 2001) and Medical Care Law (adopted in December 1997 and revised in August 2000) outline the state’s obligation to protect the right to health of its citizens. Article 8 of the Public Health Law states the government’s responsibility to “develop exchange and co-operation in the field of health service with other countries and international organizations”. In section 5.3, other relevant provisions within North Korean law will be examined in greater detail.

5.2. HEALTH CARE FACILITIES

The Committee on Economic, Social and Cultural Rights (CESCR) has explained that the right to health requires that health and health care facilities, goods and services be available, accessible, acceptable and of good quality.¹⁷⁵ This means, among other things, that:

- A sufficient quantity of health facilities, trained professionals and essential medicines must be available.

- Health facilities, goods and services on health must be physically and economically accessible (within easy reach and affordable) to everyone without discrimination.
- Health facilities, goods, services and information must be acceptable, that is respect medical ethics, be culturally appropriate and sensitive to gender requirements.
- Health facilities, goods, services and information must also be scientifically and medically appropriate and of good quality. This requires, among other things, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment and adequate sanitation.

Regarding health facilities, goods and services, the CESCR stated that article 12.2(d) includes both physical and mental sickness and:

"the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care. A further important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels".¹⁷⁶

In order to fulfil state obligation to realize the right to health, the CESCR recommended "actions that create, maintain and restore the health of the population", including "the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services". States parties are obliged "to provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them".¹⁷⁷

Furthermore, the Committee interprets the underlying determinants of health to include "access to health-related education and information". The Committee explains that obligations under article 12.2(d), which provides for "the creation of conditions which would assure to all medical service and medical attention in the event of sickness", include "the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education".

With regard to the right to health, article 12 of the CEDAW provides that:

"1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

In 1999, the CEDAW Committee noted that:

“the full realization of women's right to health can be achieved only when States parties fulfil their obligation to respect, protect and promote women's fundamental human right to nutritional well-being throughout their life span by means of a food supply that is safe, nutritious and adapted to local conditions. Towards this end, States parties should take steps to facilitate physical and economic access to productive resources especially for rural women, and to otherwise ensure that the special nutritional needs of all women within their jurisdiction are met.”¹⁷⁸

The Committee also called for states parties to report on:

“measures taken to eliminate barriers that women face in gaining access to health care services and what measures they have taken to ensure women timely and affordable access to such services. Barriers include requirements or conditions that prejudice women's access such as high fees for health care services, the requirement for preliminary authorization by spouse, parent or hospital authorities, distance from health facilities and absence of convenient and affordable public transport.”¹⁷⁹

Article 24 of the CRC states that:

“1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the

present article. In this regard, particular account shall be taken of the needs of developing countries.”

5.3. HEALTH CARE AVAILABILITY, ACCESSIBILITY AND QUALITY

The CESCR has identified “interrelated and essential elements” pertaining to the right to health of all individuals that all states, irrespective of their wealth, must fulfil. For example, with regards to availability:

“Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party’s developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drug.”¹⁸⁰

The Committee also addressed the government’s responsibility in providing accessibility:

“(b) Accessibility. Health facilities, goods and services⁶ have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

(i) Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.¹⁸¹

(ii) Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

(iii) Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

(iv) Information accessibility: accessibility includes the right to seek, receive and impart information and ideas¹⁸² concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.”¹⁸³

As well as quality:

“As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.”¹⁸⁴

With respect to domestic law, Article 72 of the North Korean Constitution stipulates that:

“[c]itizens shall have the right to receive free medical care, and persons who are no longer able to work due to old age, illness, or physical disability, and the old and children who do not have caretakers, shall have the right to receive material assistance. This right shall be guaranteed by free medical care, continuously expanding medical facilities that include hospitals and sanitariums, and the state social insurance and the social security system.”

Article 9 of the Public Health Law provides for the right of all North Koreans to universal health care:

“The State provides every citizen with the benefits of complete free medical service. The workers, farmers, working intellectuals and all the rest of the citizens have the right to free medical treatment.”

Article 15 elaborates on the availability and accessibility of health care facilities:

“The state shall reasonably arrange and manage in an up-to-date way the hospitals and clinics throughout the city and rural community; factories; enterprises; seaside villages; forest villages; and shall establish specialized hospitals and sanatorium including midwifery hospitals, children’s hospitals in many places, and shall ceaselessly improve the level of specialized medical care in order for people to get treated whenever and wherever without inconvenience.”

Article 49 of the Medical Care Law also provides for monitoring, evaluation and accountability mechanisms:

“The monitoring and controlling of health care services shall be conducted by the Health Guidance Agency and relevant monitoring and controlling agencies.”

6. CONCLUSION AND RECOMMENDATIONS

Although it has been almost two decades since North Korea was hit by famine, the country continues to face a food and economic crisis, which is taking a heavy toll on the health of the population. Despite assertions by the North Korean government that “everyone in the DPRK receives medical service of all categories equally, practically and free of charge”,¹⁸⁵ interviews with North Koreans, corroborating evidence and other research demonstrate that the North Korean government has not met its obligations to respect, protect and fulfil the right to health of its citizens. This report has documented the devastating impact of long-term food insecurity on the population’s health, the country’s decaying health care infrastructure, failure to provide basic health care, and a lack of public health education and information.

Amnesty International urges the North Korean government to ensure that the state meets its national and international obligations to respect, protect and fulfil the right to health, guaranteeing the equitable distribution of health facilities, goods and services, protecting the right of access to health care facilities, goods and services, and eliminating economic and physical barriers. Amnesty International also urges the North Korean government to guarantee access to public health information in general, and information on infections and diseases in particular. The organization calls on the government to co-operate closely with the UN in addressing food insecurity, health and other related issues in the country.

In view of the above, Amnesty International makes the following recommendations.

To the North Korean government:

- as a matter of priority, ensure that food shortages are acknowledged and effective steps taken to address these shortages, including acceptance of needed international humanitarian assistance;
- ensure the need-based and equitable distribution of health facilities, goods and services throughout the country;
- co-operate with the World Food Programme and donors, allow unrestricted access to independent monitors, and ensure non-discrimination, transparency and openness in the distribution of food aid;
- ensure implementation of universal health care, enshrined in the Constitution and Public Health Law;
- prioritise the needs of marginalized sections of the population – the very poor, elderly, pregnant and lactating women, and young children;
- ensure that medical personnel are paid adequately and regularly so that they may carry out their duties properly;

- ensure that, in accordance with article 49 of the Medical Care Law, informal and inappropriate fees are not levied by medical personnel;
- undertake information and education campaigns to provide accurate and comprehensive information on prevalent infections and diseases; their causes, symptoms and treatment; and the importance of medical diagnosis and effective use of medicines;
- ensure that the supplies and equipment necessary to maintain hygienic conditions are available and that medical personnel are trained to maintain hygienic standards;
- strengthen monitoring, evaluation and accountability mechanisms, especially regarding the procurement, storage and distribution of drugs and supplies;
- ensure that reliable transport to emergency medical facilities is available to all;
- ensure that its food and health policies are free of political considerations and are guided purely by the North Korea's obligation to respect, protect and fulfil the population's right to the enjoyment of the highest attainable standard of health conducive to living a life in dignity and the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

To the international community, and in particular, major donors and neighbouring countries such as China, Japan, Russian Federation, South Korea and US to :

- work with and support the World Food Programme and other humanitarian organizations in their efforts to strengthen the monitoring of distribution systems for food and other essential items such as medicines;
- provide international co-operation and assistance where necessary to ensure minimum essential levels of food for the whole population, which is sufficient, nutritionally adequate and safe, to ensure their freedom from hunger;
- provide international co-operation and assistance where necessary to ensure access to essential health care for the whole population;
- ensure that the provision of humanitarian assistance in North Korea is based on need and is not subject to political conditions;
- ensure that all countries, and in particular China, which is the primary exit route for the majority of North Koreans, respect the fundamental principle of *non-refoulement* and the right of North Koreans to seek and enjoy asylum.

7. APPENDIX: MAP OF NORTH KOREA



Map No. 4163 Rev. 2 UNITED NATIONS
January 2004

Department of Peacekeeping Operations
Cartographic Section

8. ENDNOTES

¹ Amnesty International interview with Lee in Seoul, South Korea on 19 December 2009.

² According to the latest UN statistics for 2008, North Korea's population stands at 23,906,000 (UN Population Division, *World Population Prospects: The 2008 Revision*, 2008). However, this report uses the 2006 UN population figure of 23,790,000 (2006 revised World Population Prospects, UN Population Division, 2007) in order to be consistent with other UN data used in this report.

³ Amnesty International, *Starved of Rights: Human rights and the food crisis in the Democratic People's Republic of Korea (North Korea)*, 17 January 2004, AI Index: ASA 24/003/2004.

⁴ Including Korea Peace Institute, National Medical Centre and Yeomyung School.

⁵ Both the Yalu and Tumen Rivers run along the North Korean-Chinese border. However unlike the Yalu River, the Tumen is shallow and narrow, and thus, North Koreans' preferred crossing route into China.

⁶ WFP, "Countries: Democratic People's Republic of Korea", available at: <http://www.wfp.org/countries/korea-democratic-peoples-republic-dprk>, accessed 23 April 2010.

⁷ Bomi Lim, "North Korea's food aid will run out next month, UN Agency says", *Bloomberg*, 3 May 2010, available at: <http://www.bloomberg.com/apps/news?pid=20601101&sid=amQ12YclAjSk>, accessed 27 May 2010, "N. Korea food crisis to worsen after poor harvest", *AFP*, 9 February 2010 and "Food shortage worsens in N. Korea: official", *Yonhap News*, 10 February 2010, available at: <http://english.yonhapnews.co.kr/northkorea/2010/02/10/21/0401000000AEN20100210001700315F.HTML>, accessed 4 April 2010.

⁸ CESCR, General Comment 14: The right to the highest attainable standard of health, UN Doc. E/C.12/2000/4 (2000), para3.

⁹ Nicholas Eberstadt, Marc Rubin and Albina Tretyakova, "The Collapse of Soviet Union and Russian Trade with the DPRK, 1989-1993: Impact and Implications", *Korean Journal of National Unification*, Volume 4, 1994, pp87-104 and FAO and WFP, *Special Report: FAO/WFP Crop and Food Supply Assessment: Mission to the Democratic People's Republic of Korea*, 29 July 2002.

¹⁰ See FAO, "Global Forum on Food Security and Nutrition: Glossary", available at: <http://km.fao.org/fsn/resources/glossary/en>, accessed 25 May 2010 and WFP, "Hunger Glossary", available at: <http://www.wfp.org/hunger/glossary>, accessed 25 May 2010.

¹¹ The CESCR comprises of experts nominated by governments but acting independently of them. See the Committee web-site at: <http://www2.ohchr.org/english/bodies/cescr>, accessed 3 June 2010.

¹² CESCR, General comment 14, para_43.

¹³ The PDS comprises of a very extensive system through which subsidised rations are distributed on a grams per day per person basis, according to occupation. It does not cover workers on cooperative farms who depend on their own production. Access to state food supplies – including domestic agricultural production, imports and aid – is determined by status, with priority given to government and ruling party officials, important military units and residents of the capital Pyongyang. See Amnesty International, *Starved of Rights: Human rights and the food crisis in the Democratic People's Republic of Korea (North Korea)*, 17 January 2004, AI Index: ASA 24/003/2004, p8.

¹⁴ Andrew S. Natsios, *The Great North Korean Famine: Famine Politics, and Foreign Policy*, US Institute of Peace Press (USIP), 2002, pp81-82.

¹⁵ Andrew S. Natsios, *The Great North Korean Famine: Famine Politics, and Foreign Policy*, USIP, 2002, pp81-82.

¹⁶ FAO/WFP, *Executive Summary: Rapid Food Security Assessment: Democratic People's Republic of Korea*, June/July 2008, p3, available at: www.fao.org/giews/english/alert/dprk2008.pdf, accessed 30 May 2010.

¹⁷ FAO/WFP, *Executive Summary: Rapid Food Security Assessment: Democratic People's Republic of Korea*, June/July 2008, p3, available at: www.fao.org/giews/english/alert/dprk2008.pdf, accessed 30 May 2010.

¹⁸ FAO/WFP, *Special Report: FAO/WFP Crop and Food Security Assessment Mission to the Democratic People's Republic of Korea*, 8 December 2008, pp23-24.

¹⁹ FAO/WFP, *Special Report: FAO/WFP Crop and Food Security Assessment Mission to the Democratic People's Republic of Korea*, 8 December 2008, p22.

²⁰ WFP, "North Korea allows WFP access to 171 counties; 39 still inaccessible", WFP press release, 18 May 1998, available at: <http://one.wfp.org/english/?ModuleID=137&Key=300>, accessed 20 June 2010.

²¹ FAO/WFP, *Special Report: FAO/WFP Crop and Food Security Assessment Mission to the Democratic People's Republic of Korea*, 8 November 1999 and WFP, "WFP DPR Korea Update" Nos 22 (30 November 2000) and 34 (November 2001).

²² WFP, "WFP seeks strong backing for new aid initiative in North Korea", WFP press release, 3 December 2002, available at: <http://one.wfp.org/english/?ModuleID=137&Key=579>, accessed 20 June 2010.

²³ Fiona Terry, "Feeding the dictator", *The Guardian*, 6 August 2001, accessed at: <http://www.guardian.co.uk/world/2001/aug/06/famine.comment>, accessed 3 March 2010, Roberta Cohen, "North Korea – Aid meant for the hungry", *New York Times*, 16 May 2002, and Hazel Smith, *Hungry for Peace: International security, humanitarian assistance, and social change in North Korea*, United States Institute of Peace, 2005, pp111 and 127.

²⁴ David Rennie, "Oxfam Halts Aid Work In North Korea", *Telegraph*, 15 December 1999. In 2002, Oxfam returned to North Korea but as a non-residential partner. See Hazel Smith, *Hungry for Peace: International security, humanitarian assistance, and social change in North Korea*, United States Institute of Peace Press, 2005, p127.

²⁵ FAO/WFP, *Special Report: FAO/WFP Crop and Food Security Assessment Mission to the Democratic People's Republic of Korea*, 8 December 2008, pp27-28.

²⁶ WFP, "Countries: Democratic People's Republic of Korea", available at: <http://www.wfp.org/countries/korea-democratic-peoples-republic-dprk>, accessed 23 April 2010.

²⁷ Under this longstanding policy, WFP insists that its monitors have full access to aid distribution to ensure that food reaches intended recipients. See <http://www.wfp.org/countries/korea-democratic-peoples-republic-dprk>, accessed 30 May 2010.

²⁸ However in 2009, the time period increased from 24 hours to seven days, which remains the current

notice period required for visits.

²⁹ Human Rights Council, *Report of the Special Rapporteur on the situation of human rights in the Democratic People's Republic of Korea*, UN doc. A/HRC/13/47, 17 February 2010, para18 and WFP, "Countries: Democratic People's Republic of Korea", available at: <http://www.wfp.org/countries/korea-democratic-peoples-republic-dprk>, accessed 23 April 2010.

³⁰ Human Rights Council, *Report of the Special Rapporteur on the situation of human rights in the Democratic People's Republic of Korea*, UN doc. A/HRC/13/47, 17 February 2010, para19.

³¹ WFP News Release, "WFP set to resume operations in North Korea", 5 November 2006, available at: <http://www.wfp.org/node/568>, accessed 23 April 2010 and "North Korea rejects UN food aid", *BBC News*, 23 September 2005, available at: <http://news.bbc.co.uk/1/hi/4273844.stm>, accessed 23 April 2010.

³² Tania Branigan, "North Korea turns down US food aid", *Guardian*, 18 March 2009, available at: <http://www.guardian.co.uk/world/2009/mar/18/north-korea-us-food-aid>, accessed 28 May 2009 and Hwang Doo-yong, "N. Korea refuses to accept further food aid from U.S.: State Dept.", *Yonhap News*, 18 March 2009.

³³ Christian Friends of Korea, Global Resource Services, Mercy Corps, Samaritan's Purse and World Vision.

³⁴ "US willing to resume food aid to North Korea", *AFP*, 23 March 2010.

³⁵ Dick K Nanto, Mark E Manyin and Kerry Dumbaugh, *China-North Korea Relations*, Congressional Research Service (CRS), 22 January 2010, available at: www.fas.org/sgp/crs/row/R41043.pdf, accessed 20 June 2010.

³⁶ Ministry of Unification, *Monthly Report on Inter-Korean Exchanges & Cooperation*, April 2010 (in Korean), available at: <http://www.unikorea.go.kr/kr/CMSF/CMSFsub.jsp?topmenu=2&menu=3&sub=0>, accessed 29 May 2010.

³⁷ Christian Oliver, "Man in the News: Lee Myung-bak", *Financial Times*, 28 May 2010, available at: <http://www.ft.com/cms/s/0/30415b5c-6a86-11df-b282-00144feab49a.html>, accessed 20 June 2010.

³⁸ "S Korea offers food aid to North", *BBC News*, 26 October 2009, available at: <http://news.bbc.co.uk/2/hi/asia-pacific/8325367.stm>, accessed 3 March 2010.

³⁹ From the Korean Red Cross.

⁴⁰ Blaine Harden, "Inflation-hit North Korea has fired top economic officials, South's media report", *Washington Post*, 5 February 2010, available at: <http://www.washingtonpost.com/wp-dyn/content/article/2010/02/04/AR2010020401472.html>, accessed 4 April 2010 and Bill Varner, "North Korea's Currency Revaluation Led to Food Crisis, UN Says", *Bloomberg BusinessWeek*, available at: <http://www.businessweek.com/news/2010-03-15/north-korean-currency-revaluation-led-to-food-crisis-un-says.html>, accessed 4 April 2010.

⁴¹ Human Rights Council, *Report of the Special Rapporteur on the situation of human rights in the Democratic People's Republic of Korea*, UN doc. A/HRC/13/47, 17 February 2010, paras21-22 and "North Korea relaxes free market restrictions", *BBC News*, 4 February 2010, available at: <http://news.bbc.co.uk/2/hi/8497603.stm>, accessed 4 April 2010.

⁴² Good Friends, *North Korea Today No. 311*, December 2009. See also “North Korea relaxes free market restrictions”, *BBC News*, 4 February 2010, available at: <http://news.bbc.co.uk/2/hi/8497603.stm>, accessed 4 April 2010; Bill Varner, “North Korea’s Currency Revaluation Led to Food Crisis, UN Says”, *Bloomberg BusinessWeek*, available at: <http://www.businessweek.com/news/2010-03-15/north-korean-currency-revaluation-led-to-food-crisis-un-says.html>, accessed 4 April 2010; “Sudden changes in N.K.”, *Korea Herald*, 29 March 2010; Choe Sang-Hun, “North Korea Revalues Its Currency”, *New York Times*, 1 December 2009, available at: <http://www.nytimes.com/2009/12/02/business/global/02korea.html>, accessed 4 April 2010.

⁴³ Good Friends, *North Korea Today No. 335*, March 2010.

⁴⁴ Barbara Demick, “North Koreans fear another famine amid economic crisis”, *Los Angeles Times*, 25 March 2010, available at: <http://articles.latimes.com/2010/mar/23/world/la-fg-korea-famine24-2010mar24>, accessed 24 April 2010 and “North Korea relaxes free market restrictions”, *BBC News*, 4 February 2010, available at: <http://news.bbc.co.uk/1/hi/8497603.stm>, accessed 24 April 2010.

⁴⁵ In an effort to maintain control in economic spheres and “traditional” Korean society, the North Korean authorities have prohibited women from wearing trousers, except in winter, and riding bicycles. See Citizens’ Alliance for North Korean Human Rights, *Flowers, Guns and Women on Bikes: Briefing Report on the Situation of Women’s Rights in the DPRK*, 2009, pp16-17 and Human Rights Council, *Report of the Special Rapporteur on the situation of human rights in the Democratic People’s Republic of Korea*, UN doc. A/HRC/10/18, 24 February 2009, para14.

⁴⁶ FAO/WFP, *Executive Summary: Rapid Food Security Assessment: Democratic People’s Republic of Korea*, June/July 2008, p2, available at: www.fao.org/giews/english/alert/dprk2008.pdf, accessed 30 May 2010.

⁴⁷ Human Rights Council, *Report of the Special Rapporteur on the situation of human rights in the Democratic People’s Republic of Korea*, UN doc. A/HRC/10/18, 24 February 2009, para15.

⁴⁸ FAO/WFP, *Special Report: FAO/WFP Crop and Food Security Assessment Mission to the Democratic People’s Republic of Korea*, 8 December 2008, p25.

⁴⁹ The FAO and WFP conducted the RFSAs in eight provinces: Ryanggang, North Hamgyong, South Hamgyong, Kangwon, North Hwanghae, South Hwanghae, South Pyongan, and Pyongyang. Five US NGOs conducted a similar survey in western Chagang and North Pyongan provinces in 2008/09. See FAO/WFP, *Special Report: FAO/WFP Crop and Food Security Assessment Mission to the Democratic People’s Republic of Korea*, 8 December 2008, p30.

⁵⁰ FAO/WFP, *Executive Summary: Rapid Food Security Assessment: Democratic People’s Republic of Korea*, June/July 2008, p2, available at: www.fao.org/giews/english/alert/dprk2008.pdf, accessed 30 May 2010.

⁵¹ FAO/WFP, *Special Report: FAO/WFP Crop and Food Security Assessment Mission to the Democratic People’s Republic of Korea*, 8 December 2008, p31. Also, see endnote 2.

⁵² WFP, “Countries: Democratic People’s Republic of Korea”, available at: <http://www.wfp.org/countries/korea-democratic-peoples-republic-dprk>, accessed 27 May 2010.

⁵³ FAO/WFP, *Special Report: FAO/WFP Crop and Food Security Assessment Mission to the Democratic People’s Republic of Korea*, 8 December 2008, p26.

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- ⁵⁴ FAO/WFP, *Executive Summary: Rapid Food Security Assessment: Democratic People's Republic of Korea*, June/July 2008, p3, available at: www.fao.org/giews/english/alert/dprk2008.pdf, accessed 30 May 2010.
- ⁵⁵ Amnesty International interview with Yoo in Seoul, South Korea on 3 December 2009.
- ⁵⁶ Amnesty International interview with Lee in Seoul, South Korea on 19 December 2009.
- ⁵⁷ See map in Appendix 1.
- ⁵⁸ Amnesty International interview with Shin in Seoul, South Korea on 10 December 2009.
- ⁵⁹ Amnesty International interview with Na in Seoul, South Korea on 11 December 2009.
- ⁶⁰ Amnesty International interview with Kim in Seoul, South Korea on 3 December 2009.
- ⁶¹ Amnesty International interview with Tak in Seoul, South Korea on 9 December 2009.
- ⁶² Amnesty International interview with Bae in Seoul, South Korea on 14 December 2009.
- ⁶³ *Kkotjebi* literally means "flower swallow" in Korean and refers to North Korean homeless children. This term has broadened to include all homeless people who often congregate around markets and railway stations searching for food and shelter.
- ⁶⁴ Amnesty International interview with Hwang in Seoul, South Korea on 11 March 2010.
- ⁶⁵ Aspirin is not the recommended drug of choice for gastrointestinal problems.
- ⁶⁶ Amnesty International interview with Na in Seoul, South Korea on 11 December 2009.
- ⁶⁷ Hong Young-lim, "N. Koreans are smaller, weaker than S. Koreans", *Daily Chosun*, 17 February 2010, available at: http://english.chosun.com/site/data/html_dir/2010/02/17/2010021700270.html, accessed 17 June 2010.
- ⁶⁸ Wild food, such as grasses, mushrooms, roots and seaweed, are traditional foods eaten in North Korea. However, during the food shortages, the very poor began to forage for less commonly eaten varieties, which can be poisonous and cause digestive problems.
- ⁶⁹ Amnesty International interview with Hwang in Seoul, South Korea on 11 March 2010.
- ⁷⁰ Amnesty International interview with Park in Seoul, South Korea on 10 March 2010.
- ⁷¹ NS Scrimshaw and JP SanGiovanni, "Synergism of nutrition, infection, and immunity: an overview", *American Journal of Clinical Nutrition*, volume 66, pp464S-477S, available at: <http://www.ajcn.org/cgi/content/abstract/66/2/464S>, accessed 21 May 2010.
- ⁷² WFP, "Korea, Democratic People's Republic (DPRK): Overview", available at: <http://www.wfp.org/countries/korea-democratic-peoples-republic-dprk>, accessed 18 May 2010.
- ⁷³ See WFP, "Hunger Glossary", available at: <http://www.wfp.org/hunger/glossary>, accessed 25 May 2010.
- ⁷⁴ UNICEF, *Tracking Progress on Child and Maternal Nutrition: A survival and development priority*, November 2009, pp11 and 104, available at: http://www.unicef.org.uk/publications/pdf/nutrition_report2009.pdf, accessed 7 March 2010.
- ⁷⁵ "One third of N Korean women, children malnourished: WFP", *AFP*, 6 September 2009.

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- ⁷⁶ See “Nutrition: Challenges”, <http://www.who.int/nutrition/challenges/en>, accessed 27 April 2010.
- ⁷⁷ Ulrich E Schaible and Stefan HE Kaufmann, “Malnutrition and Infection: Complex mechanisms and global impacts”, *PLoS Med*, 4(5): e115, 1 May 2007.
- ⁷⁸ WHO, “WHO Country Cooperation Strategy 2004-2008: Democratic People’s Republic of Korea”, June 2003, available at: <http://www.dprk.searo.who.int/EN/Section16.htm>, accessed 30 May 2010, p10.
- ⁷⁹ The WHO has used data from the 2006 revised World Population Prospects, UN Population Division, 2007.
- ⁸⁰ Stephen Glain, “Giving until It Hurts”, *The Washington Post*, 9 March 2008, available at: <http://www.washingtonpost.com/wp-dyn/content/article/2008/03/04/AR2008030402500.html>, accessed 31 March 2010.
- ⁸¹ WHO, *Global tuberculosis control: epidemiology, strategy, financing: WHO report 2009*, 2009, UN doc. WHO/HTM/TB/2009.411, available at: http://www.who.int/tb/publications/global_report/en/, accessed 4 April 2010.
- ⁸² For data sources and analytical methods, see WHO, *Global tuberculosis control: epidemiology, strategy, financing: WHO report 2009*, 2009, UN doc. WHO/HTM/TB/2009.411, pp32-35, available at: http://www.who.int/tb/publications/global_report/en/, accessed 4 April 2010.
- ⁸³ See WHO, “Tuberculosis”, Fact sheet No.104, March 2010, available at: <http://www.who.int/mediacentre/factsheets/fs104/en>, accessed 17 June 2010 and National Health Service (NHS), “Tuberculosis: Overview”, available at: <http://www.nhs.uk/conditions/Tuberculosis/Pages/Introduction.aspx>, accessed 17 June 2010.
- ⁸⁴ Eugene Bell Foundation, “Helping Tuberculosis Patients”, available at: <http://www.eugenebell.org>, accessed 30 March 2010.
- ⁸⁵ Stephen Glain, “Giving until It Hurts”, *The Washington Post*, 9 March 2008, available at: <http://www.washingtonpost.com/wp-dyn/content/article/2008/03/04/AR2008030402500.html>, accessed 31 March 2010 and Stephanie Mann, “North Korea: Tuberculosis”, *VOA*, 3 May 1999, available at: <http://www.fas.org/news/dprk/1999/990428-dprk2.htm>, accessed 30 March 2010.
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- ⁸⁷ WHO, “Scoping meeting for the development of guidelines on nutritional/food support to prevent TB and improve health status among TB patients”, 2-4 November 2009, Geneva, Switzerland, available at: http://www.who.int/nutrition/topics/meeting_nutrition_and_tb/en/index.html, accessed 21 May 2010.
- ⁸⁸ Directly Observed Treatment Short-Course (DOTS) is the WHO-recommended TB control strategy combining five elements: 1.Political commitment with increased and sustained financing, 2.Case detection through quality-assured bacteriology, 3.Standardized treatment, with supervision and patient support, 4.An effective drug supply and management system, and 5.Monitoring and evaluation system, and impact measurement. See WHO, “Treatment of tuberculosis: guidelines” (4th ed.), UN doc. WHO/HTM/TB/2009.420, Geneva, 2010, available at: http://whqlibdoc.who.int/publications/2010/9789241547833_eng.pdf, accessed 24 May 2010 and WHO, “Building on and enhancing DOTS to meet the TB-related Millennium Development Goals”, Geneva, 2006.

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- ⁹³ WHO recommendations for treatment of tuberculosis are constantly under review. At the core of the strategy remains directly observed treatment of patients. This was introduced to overcome the problem of patients ceasing their medication before the prescribed period. See WHO, “Treatment of tuberculosis: Guidelines” (4th ed.), UN doc. WHO/HTM/TB/2009.420, Geneva, 2010, available at: http://whqlibdoc.who.int/publications/2010/9789241547833_eng.pdf, accessed 24 May 2010 and WHO, “Building on and enhancing DOTS to meet the TB-related Millennium Development Goals”, Geneva, 2006.
- ⁹⁴ Amnesty International interviews with Kwon in Seoul, South Korea on 7 October 2009 and 2 May 2010.
- ⁹⁵ The surgery would have cost KPW400-500,000. According to Park, for this amount of money, a family could eat for six months. At that time, one kilogram of rice cost KPW900.
- ⁹⁶ Amnesty International interviews with Park in Seoul, South Korea on 11 December 2009 and 10 March 2010.
- ⁹⁷ See WHO, “Anaemia”, available at: <http://www.who.int/topics/anaemia/en>, accessed 6 March 2010.
- ⁹⁸ WHO, “Anaemia”, available at: <http://www.who.int/topics/anaemia/en>, accessed 15 June 2010.
- ⁹⁹ NHS, “Causes of iron deficiency anaemia”, available at: <http://www.nhs.uk/Conditions/Anaemia-iron-deficiency-/Pages/Causes.aspx>, accessed 30 June 2010.
- ¹⁰⁰ WHO, “Making Pregnancy Safer: Reduction of maternal mortality”, available at: <http://www.wpro.who.int/internet/files/pub/360/115.pdf>, accessed 16 June 2010 and Academy for Educational Development, “Maternal Anemia: A Preventable Killer”, August 2006, available at: <http://www.aed.org/Publications/upload/FANTAanemia2006.pdf>, accessed 16 June 2010.
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- ¹⁰² Hong Young-lim, “N. Koreans are smaller, weaker than S. Koreans”, *Daily Chosun*, 17 February 2010, available at: http://english.chosun.com/site/data/html_dir/2010/02/17/2010021700270.html, accessed 17 June 2010.

- ¹⁰³ Amnesty International interview with Sohn in Seoul, South Korea on 11 March 2010.
- ¹⁰⁴ Amnesty International interview with Lim in Seoul, South Korea on 10 March 2010.
- ¹⁰⁵ There is no data available for Somalia. See WHO, "World Health Statistics 2009", 2009, available at: <http://www.who.int/whosis/whostat/2009/en>, accessed 30 May 2010, pp108-109 and WHO, "Country health profile", available at: <http://www.who.int/countries/prk/en/>, accessed 30 May 2010.
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- ¹⁰⁷ North Korea is geographically divided into provinces, municipalities and counties. Within counties, there are further administrative divisions called *ri* in rural areas and *dong* in urban areas.
- ¹⁰⁸ WHO, "WHO Country Cooperation Strategy 2004-2008: Democratic People's Republic of Korea", June 2003, available at: <http://www.dprk.searo.who.int/EN/Section16.htm>, accessed 30 May 2010, p5.
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- ¹¹⁰ WHO, "WHO Country Cooperation Strategy 2004-2008: Democratic People's Republic of Korea", June 2003, available at: <http://www.dprk.searo.who.int/EN/Section16.htm>, accessed 30 May 2010, p6.
- ¹¹¹ WHO, "WHO Country Cooperation Strategy 2004-2008: Democratic People's Republic of Korea", June 2003, available at: <http://www.dprk.searo.who.int/EN/Section16.htm>, accessed 30 May 2010, p5.
- ¹¹² Caroline Gluck, "N Korea healthcare 'near collapse'", *BBC News*, 20 November 2001, available at: <http://news.bbc.co.uk/1/hi/world/asia-pacific/1666806.stm>, accessed 6 May 2010.
- ¹¹³ WHO, "WHO Country Cooperation Strategy 2004-2008: Democratic People's Republic of Korea", June 2003, available at: <http://www.dprk.searo.who.int/EN/Section16.htm>, accessed 30 May 2010, p11.
- ¹¹⁴ UN, "UN agency chief urges strengthening of health care in DPR Korea", 30 April 2010.
- ¹¹⁵ The latest statistics for North Korea are for 2006. See WHO, "World Health Statistics 2009", 2009, available at: <http://www.who.int/whosis/whostat/2009/en>, accessed 30 May 2010 (the 2010 edition does not contain statistics on health expenditures for North Korea).
- ¹¹⁶ CIA, "Country Comparison: GDP – per capita (purchasing power parity)", *The World Factbook*, 2007. Figures in the 2007 edition are based on the year 2006.
- ¹¹⁷ The WHO Western Pacific Region includes Australia, Brunei Darussalam, Cambodia, China, Cook Islands, Fiji, Japan, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Nauru, New Zealand, Niue, Palau, Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Tuvalu, Vanuatu and Viet Nam.
- ¹¹⁸ WHO field missions were conducted from 21-31 October 2000 and 18-25 March 2003.
- ¹¹⁹ WHO, "WHO Country Cooperation Strategy 2004-2008: Democratic People's Republic of Korea", June 2003, available at: <http://www.dprk.searo.who.int/EN/Section16.htm>, accessed 30 May 2010, p12.
- ¹²⁰ Implementation of the ICESCR, second periodic reports submitted by States parties under articles 16 and 17 of the Covenant: Democratic People's Republic of Korea, UN doc. E/1990/6/Add.35, 15 May 2002, para68.

- ¹²¹ National Report Submitted in Accordance with Paragraph 15 (A) of the Annex to Human Rights Council Resolution 5/1: Democratic People's Republic of Korea, UN doc. A/HRC/WG.6/6/PRK/1, 27 August 2009, para62.
- ¹²² Amnesty International interview with Heo in Seoul, South Korea on 2 December 2009.
- ¹²³ Amnesty International interview with Rhee in Seoul, South Korea on 19 December 2009.
- ¹²⁴ Amnesty International interview with Tak in Seoul, South Korea on 9 December 2009.
- ¹²⁵ Amnesty International interview with Joo in Seoul, South Korea on 16 December 2009.
- ¹²⁶ Amnesty International interview with Hong in Seoul, South Korea on 10 March 2010.
- ¹²⁷ WHO, "WHO Country Cooperation Strategy 2004-2008: Democratic People's Republic of Korea", June 2003, available at: <http://www.dprk.searo.who.int/EN/Section16.htm>, accessed 30 May 2010, pp11-12.
- ¹²⁸ Amnesty International interview with Kim in Seoul, South Korea on 3 December 2009.
- ¹²⁹ Amnesty International interview with Song in Seoul, South Korea on 5 December 2009.
- ¹³⁰ Amnesty International interview with Hwang in Seoul, South Korea on 11 March 2010.
- ¹³¹ Amnesty International interview with Chun in Seoul, South Korea on 10 March 2010.
- ¹³² Amnesty International interview with Song in Seoul, South Korea on 5 December 2009.
- ¹³³ This is due to the fact that North and South Korea are technically still at war, as the Korean War (1950-53) ended in an armistice. The "Sunshine Policy" or policy of engagement, under the South Korean presidencies of Kim Dae-jung and Roh Moo-hyun (1998-2008), improved relations with the North, but tension between the two countries has increased since South Korean President Lee Myung-bak came into power.
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- ¹³⁵ Amnesty International interview with Hong in Seoul, South Korea on 10 March 2010.
- ¹³⁶ Stephanie Mann, "North Korea: Tuberculosis", *VOA*, 3 May 1999, available at: <http://www.fas.org/news/dprk/1999/990428-dprk2.htm>, accessed 30 March 2010.
- ¹³⁷ Stephen Glain, "Giving until It Hurts", *The Washington Post*, 9 March 2008, available at: <http://www.washingtonpost.com/wp-dyn/content/article/2008/03/04/AR2008030402500.html>, accessed 31 March 2010.
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- ¹³⁹ See section 4.1.
- ¹⁴⁰ Amnesty International interview with Tak in Seoul, South Korea on 9 December 2009.
- ¹⁴¹ Kim Eun-ji, "North Korean Escapees were excessively taking drugs prior to arrival in South Korea", *VOA News*, 29 July 2009 (in Korean), available at: <http://www.voanews.com/Korean/archive/2009->

07/2009-07-29-voa16.cfm, accessed 24 March 2010.

¹⁴² Amnesty International interview with Min in Seoul, South Korea on 14 December 2009.

¹⁴³ Good Friends, *North Korea Today No. 315-1*, December 2009.

¹⁴⁴ Hanawon is a settlement centre run by the South Korean government. Located in Anseong, Gyeonggi province, North Korean settlers are enrolled in a 12-week programme designed to ease social and cultural adjustment to South Korean society, including overcoming difficulties in finding employment. See "Settlement Support for Dislocated North Koreans", Ministry of Unification, available at: http://www.unikorea.go.kr/eng/default.jsp?pgname=AFFhumanitarian_settlement, accessed 29 March 2010.

¹⁴⁵ Kim Eun-ji, "North Korean Escapees were excessively taking drugs prior to arrival in South Korea", *VOA News*, 29 July 2009 (in Korean), available at: <http://www.voanews.com/Korean/archive/2009-07/2009-07-29-voa16.cfm>, accessed 24 March 2010.

¹⁴⁶ Amnesty International interview with Huh in Seoul, South Korea on 5 December 2009.

¹⁴⁷ Amnesty International interview with Tak in Seoul, South Korea on 9 December 2009.

¹⁴⁸ Amnesty International interview with Joo in Seoul, South Korea on 16 December 2009.

¹⁴⁹ Amnesty International interview with Lim in Seoul, South Korea on 10 March 2010.

¹⁵⁰ Kim Eun-ji, "North Korean Escapees were excessively taking drugs prior to arrival in South Korea", *VOA News*, 29 July 2009 (in Korean), available at: <http://www.voanews.com/Korean/archive/2009-07/2009-07-29-voa16.cfm>, accessed 24 March 2010.

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¹⁵² Traditional Korean under floor heating using charcoal briquettes.

¹⁵³ Amnesty International interview with Sun in Seoul, South Korea on 11 December 2009.

¹⁵⁴ Implementation of the International Covenant on Economic, Social and Cultural Rights, Second periodic reports submitted by States parties under articles 16 and 17 of the Covenant: Democratic People's Republic of Korea, UN doc. E/1990/6/Add.35, 15 May 2002, para68.

¹⁵⁵ Amnesty International interview with Park in Seoul, South Korea on 29 May 2010.

¹⁵⁶ Amnesty International interview with Min in Seoul, South Korea on 27 June 2010.

¹⁵⁷ Amnesty International interview with Roh in Seoul, South Korea on 27 June 2010.

¹⁵⁸ Amnesty International interview with Kwon in Seoul, South Korea on 7 October 2009.

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¹⁶⁰ Amnesty International interview with Joo in Seoul, South Korea on 16 December 2009.

¹⁶¹ Amnesty International interview with Choi in Seoul, South Korea on 2 December 2009.

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¹⁶⁴ "Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", UN doc. A/61/338, 13 September 2006, para21 and D Maine, *Safe Motherhood Programmes: Options and Issues*, Center for Population and Family Health, Columbia University, 1991.

¹⁶⁵ CEDAW, article 14(2)(b).

¹⁶⁶ CESCR, General Comment 14, para21.

¹⁶⁷ CEDAW Committee, General Recommendation 24, Article 12: Women and health (20th session, 1999), UN Doc. HRI\GEN\1\Rev.1, para31(b).

¹⁶⁸ CESCR, General Comment 14, para43(e) and (f).

¹⁶⁹ "Second periodic report of the Democratic People's Republic of Korea on its implementation of the International Covenant on Civil and Political Rights", UN doc. CCPR/C/PRK/2000/2, 4 May 2000, para76.

¹⁷⁰ Amnesty International interview with Ahn in Seoul, South Korea on 2 December 2009.

¹⁷¹ CESCR, General Comment 14, para43(b).

¹⁷² CESCR, General Comment 14 paras30 and 31.

¹⁷³ CESCR, General Comment 14, para4.

¹⁷⁴ On 9 April 2010, the Korean Central News Agency (KCNA), North Korea's state news agency, reported on the adoption of the ordinance of the DPRK Supreme People's Assembly "on revising some provisions of the DPRK Socialist Constitution". However at the time of publication of this report, the revised text was not available.

¹⁷⁵ CESCR, General Comment 14, para12.

¹⁷⁶ CESCR, General Comment 14, para17.

¹⁷⁷ CESCR, General Comment 14, paras11 and 13.

¹⁷⁸ CEDAW, General Recommendation 24 (1999), para7, available at: <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm>, accessed 16 May 2010.

¹⁷⁹ CEDAW, General Recommendation 24 (1999), para21, available at: <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm>, accessed 16 May 2010.

¹⁸⁰ CESCR, General Comment 14, para12(a).

¹⁸¹ CESCR, General Comment 14, paras18 and 19.

¹⁸² See article 19.2 of the International Covenant on Civil and Political Rights. This General Comment gives particular emphasis to access to information because of the special importance of this issue in relation to health.

¹⁸³ CESCR, General Comment 14, para12(b).

¹⁸⁴ CESCR, General Comment 14, para12(d).

¹⁸⁵ National Report Submitted in Accordance with Paragraph 15 (A) of the Annex to Human Rights Council Resolution 5/1: Democratic People's Republic of Korea, UN doc. A/HRC/WG.6/6/PRK/1, 27 August 2009, para62.



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THE CRUMBLING STATE OF HEALTH CARE IN NORTH KOREA

Nearly one million people died when famine hit the Democratic People's Republic of Korea (North Korea) in the early 1990s. Today, food shortages and a broader economic crisis continue. The government's delayed and inadequate response to the food crisis has had a devastating impact on the health of the population.

In this report, Amnesty International documents how widespread and chronic malnutrition has triggered epidemics and illnesses related to poor diet, such as tuberculosis and anaemia. Interviews with North Koreans depict a country that in theory has a universal health care system but in practice struggles to provide even the most basic service. Health facilities are rundown and prone to frequent power cuts. Medical personnel often do not receive salaries and many hospitals function without medicines and other essentials. As doctors have begun charging for their services, the poor find it increasingly difficult to access medical care.

People have little or no access to public health information. When ill, many buy medication, including narcotics, from local markets and seek medical advice from unqualified individuals.

In North Korea, the right to health cannot be separated from the food insecurity that has gripped the country for almost two decades. The government must take urgent steps to address food shortages and the crumbling health care system. Those who face the greatest barriers in accessing health services should be prioritized by the equitable distribution of health facilities throughout the country.

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