

# Rights-Based TB Programs for Migrants and Prisoners Needed in North Korea

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In early 2014, the United Nations Commission of Inquiry published a report identifying widespread rights violations amounting to crimes against humanity in the Democratic People’s Republic of Korea (DPRK).<sup>1</sup> While the report identified the system of prison camps and cross-border migration as critical to generating horrendous atrocities, it only briefly linked imprisonment and migration as contributing to poor health. Yet the system of prison camps throughout North Korea and migration across the 1,420 kilometer Sino-Korean border create double trouble for health and human rights, particularly with tuberculosis and multidrug-resistant TB (MDR-TB). TB is one of the most serious public health problems in North Korea.<sup>2</sup> Those who are detained and those who migrate are at differential risk for contracting TB, and if they do so, they are more likely than the average North Korean resident to receive little or poor treatment. The value imparted by protecting the rights of those vulnerable to TB and those with TB is instrumental for North Korea to improve the basic quality of life for all within the country.

A rights-based approach to TB in North Korea would mean that the North Korean government and its Ministry of Public Health would work toward making the highest standard of health care available, accessible, acceptable, and of good quality (AAAQ) for *all members of society, without discrimination*, including those most vulnerable to TB, such as prisoners and migrants. The benefits of such an approach would have positive impact on the entire population. Prisoners’ and migrants’ differential risk to TB increases the likelihood of contagion in the wider population. Clearly, this approach to TB in North Korea would meet with great resistance from the state. Prisoners and migrants are deemed treasonous, and are seen to have self-selected out of rights that the state would otherwise grant. Of concern is that North Korea might adopt practices aimed at reducing the burden of TB by limiting the rights of these individuals through enforced medical treatment and further deprivation of freedom.<sup>3</sup> The implication of a rights-based approach to TB in North Korea means that information about TB—how it is contracted and how it should be treated— must be accessible to all. Such an approach would mean the implementation of low-cost, targeted TB programs at re-education camps, detention centers, and prisons, which could prevent the cycle of contagion in a timely and expeditious manner. Health care facilities would be physically accessible to all, within safe reach, and medical staff should be skilled. Unexpired drugs would be administered appropriately.

The estimated rate of TB instances is 442/100,000 population.<sup>4</sup> Treatment would be hard enough in a poor country, but political antagonism, sanctions, limited international medical exchange, and systemic rights violations combine to make testing and treatment extremely difficult. MDR-TB was assumed

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to be a non-issue in North Korea because it went undocumented, but experts now estimate that drug-resistant TB may already be a serious and growing problem.<sup>5</sup>

In developed countries, treatment of TB and MDR-TB is approached through public health or strict biomedical solutions. However, underlying social and economic determinants of the disease in North Korea means focusing on the rights of people who live with or who are vulnerable to TB.<sup>6</sup> This rights-based approach necessitates identifying the value imparted in protecting the rights of people vulnerable to TB, and those with TB, particularly in terms of providing information, preventing the spread of disease, ensuring quality testing, and guaranteeing that treatment is available and accessible to all.

### Prison and TB

The extent of the TB epidemic in North Korean prisons is difficult to estimate, but we may learn from the experience of Russia and other post-Soviet states in Eastern Europe and Central Asia.<sup>7</sup> The collapse of the Soviet bloc led to an increase in inmate populations as people committed economic crimes in order to survive; this in turn led to increased rates of TB. Social conditions such as lack of access to proper, adequate diagnosis and treatment contributed to an epidemic of MDR-TB. Research by Paul Farmer and MSF identified MDR-TB in Russian prisons as so severe the prisons were labeled “TB colonies.”<sup>8</sup> Prison growth led to the spread of TB and MDR-TB in Europe and Central Asian populations overall.<sup>9</sup>

Although North Korea’s brand of socialism did not collapse with the dissolution of the Soviet bloc, the country was still profoundly affected in the form of a widespread famine that led to unprecedented migration and economic crimes for survival.<sup>10</sup> North Korea operates a network of political prison and reform-through-labor re-education camps with an estimated population, gleaned from former prisoners and satellite imagery, of as many as 150,000 and 200,000.<sup>11</sup> The UN Commission of Inquiry report states, “approximately 1 in every 200 citizens of the DPRK” are held within the camps.<sup>12</sup> The camps are a

blind spot where human rights and health are concerned.<sup>13</sup> North Korea denies their existence.<sup>14</sup> Using testimony from former prisoners, a study by the Database Center for North Korean Human Rights found medical facilities in the prisons had little function, lacked necessary medicines, and provided only rudimentary treatments and prescriptions. The skill of medical staff was very low, and prisoners assisted doctors with simple procedures.

According to former prisoners, sterilization liquids are sprayed directly onto infected individuals, resulting in toxic effects. Liquids used to sanitize toilets are used directly on people.<sup>15</sup> Some prisons have separate facilities to isolate, but not treat, contagious inmates with hepatitis or TB.<sup>16</sup> Diagnosis of TB in this environment is haphazard, given that there is little or no medical equipment. In such conditions, common colds develop into serious diseases. Cases presenting as pneumonia may be TB manifesting as a high fever with a productive cough. Prison staff deal with TB and other contagious diseases through prevention rather than treatment, leading to extremely high mortality rates. Excessive work demands, forced labor, torture, and starvation rations ensure that the correction system contributes immensely to diminished health of individuals. Since prison employees are as likely as prisoners to contract the disease, the epidemic can spread easily.<sup>17</sup> If released, prisoners are often unable to integrate into society, so many cross into China and continue onward to South Korea; if infected with TB, they contribute to contagion.<sup>18</sup>

### Migration and TB

Migration within and out of North Korea is illegal unless sanctioned by the government, yet the 1990s famine saw the onset of this coping mechanism, which is ongoing. Initial waves of migration were driven by the critical need for food, whereas contemporary migration is largely economic. Approximately 300,000 North Korean migrants reside illegally in the People’s Republic of China.<sup>19</sup> Classifying these refugees as illegal migrants, a Chinese Government embargo prevents researchers from legally conducting studies on their quality

of health. Prevalence of TB and MDR-TB in this population is largely unknown. North Koreans in China are unlikely to see a doctor because doing so would bring them to the attention of local authorities, which would result in a return to North Korea with severe punishment and incarceration.<sup>20</sup>

Threat of capture in China and imprisonment in North Korea compels many to hide for years as undocumented persons, unable to access basic health care. The language barrier also prevents many from gaining access to information. If returned to North Korea, the health care precarity of detention, re-education, and prison facilities is introduced once again. These individuals are cycled through a system of incarceration that offers no health care or disease surveillance. If they are fortunate enough to be released after some time, they risk spreading TB.

After China, the second-largest population of North Korean refugees is in South Korea, where approximately 27,000 migrants reside.<sup>21</sup> Rates and severity of TB in this population are considerable. The economic decline of North Korea since the 1990s is linked with increased rates of TB among defectors who show a high prevalence of pulmonary TB, and suffer from more severe tuberculosis in bacteriological and radiological aspects.<sup>22</sup>

Of the approximately 27,000 North Korean defectors in South Korea at present, 70% are women. Migration out of North Korea is predominantly female; when resources are short, women are more likely to cross into China or migrate within North Korea to alter their access to money and medicine for their families. Since the 1990s, women, particularly mothers, have skipped meals or reduced their food portions for the benefit of family members, resulting in a demonstrated deterioration in health.<sup>23</sup> Women and caregivers are more likely to be in contact with those who have TB, and thus more vulnerable to contracting and spreading the disease.

Migration schedules are contingent on illicit networks and subject to imprisonment or death, so migration breaks up families. Few North Koreans have mobile or land-line phones, and many fear phone-tapping, which limits communication and makes it more difficult to reconnect with separated

family. Homeless and begging children have increased in the small northern towns and provinces of North Korea since the 1990s. These are the regions from which most defectors in South Korea and China originally migrate. Called *Kotjebi* (“flowering swallows”), homeless children live in packs, steal for their livelihoods, skip school, and suffer abuse. Access to health services, not to mention food and a fixed residence, is particularly precarious for these children.<sup>24</sup> Rates of TB among children in North Korea are not well known; a WHO report from 2014 claimed that 1.9% (2,090) of the 110,000 cases in 2013 were children.<sup>25</sup> Rates of TB among homeless children in the Northern provinces are likely to be significant as this region was worst hit by the famine, is low-priority in state distribution of resources, and has suffered a slow recovery.

### International collaboration, vulnerable doctors and health workers

With the help of WHO, North Korea began implementing the DOTS (Directly Observed Treatment, Short-Course) system of treating TB in 1998; by 2003 it was in place throughout the country. However, there are indications that problems exist within DOTS at the level of implementation.<sup>26</sup> Kim Cheol-Jin, a 56-year-old North Korean refugee who was a long-term TB patient in North Korea on the DOTS program, reported being turned away from a TB hospital because there was insufficient medicine and cases were being triaged according to severity. He later saw the DOTS medicine on the black market: “DOTS drugs appeared quite conspicuously in the informal markets and in privately run pharmacies, sold at a steep price.”<sup>27</sup> Amnesty International’s 2010 report uncovered speculation from defectors that officials in the health department intercept medicines before they reach clinics and sell them for profit on the black market.<sup>28</sup>

The only NGO to earn the trust of the North Korean government is the Eugene Bell Foundation (EBF), which established connections in North Korea through its delivery of food aid in 1996. Because of the group’s medical connections, the DPRK government requested that EBF help cases of TB rather

than provide food aid. The foundation obliged; in 1998, they began offering systematic and comprehensive support to a dozen TB hospitals and more than 60 long-term treatment facilities. In time, they scaled up and offered 20 mobile vehicles equipped with x-ray machines, diagnostic equipment, and kits of DOTS medication for more than 250,000 patients. In addition to the work of the EBF, several scholars and doctors at Stanford University have established contacts with the Ministry of Public Health in North Korea. In 2008, North Korea sent several doctors from the Ministry to Stanford to learn from TB experts.

EBF publicly raised concern over finding MDR-TB in patients, stating that the disease is “much more advanced [...] than previously thought.”<sup>29</sup> The severity remains unknown. Among the 245 patients treated through the Foundation, 98% of cases did not respond to Isoniazid, 89% did not respond to Rifampicin, and 69% did not respond to Streptomycin.<sup>30</sup> The unprecedented access of EBF to patients identifies the benefits of working with the government to gain trust. WHO didn’t have this level of trust, and thought the outcomes for MDR-TB were “great.”<sup>31</sup> At present, the Eugene Bell Foundation has established the means for diagnosing MDR-TB in North Korea and is currently treating 1,500 patients with MDR-TB.

For ordinary people, medical staff, and international NGOs working in the country, lack of information and misinformation about TB are widespread. Defectors report that people view TB as so common as to not require a visit to the doctor. Many believe TB to be genetic, with the disease passed from parents to children.<sup>32</sup> Education about TB and MDR-TB is of critical importance, particularly since the economic collapse, as more individuals seek help from people who are not medically trained.<sup>33</sup>

Doctors treating TB are not always able to take precautions for their own health. This is particularly the case where “doctors” may actually be untrained people working in the black market. Furthermore, through exposure to drugs such as Isoniazid, individuals could experience side effects including memory loss. In a hospital setting, this impacts on

the ability of medical staff to treat patients, manage staff, and deal with problems.<sup>34</sup> Where there are facilities to diagnose TB in North Korea, it is done using direct fluoroscopy, which exposes doctors to radiation, particularly if they lack appropriate protective garments. Such exposure can produce long-term effects such as cataracts, osteonecrosis and inheritable genetic effects.<sup>35</sup>

Working with limited resources, doctors have developed maladaptive strategies. For example, doctors try to make scarce medicines go further by placing tubes down the trachea into the lungs and dripping medicine into the lungs on a daily basis. These methods carry the risk of secondary infection and pneumonia.<sup>36</sup> It also causes patients extreme pain as it involves inserting a long hypodermic needle into the lungs to insert the medicine directly.

## Conclusion

In North Korea, imprisonment and migration create double trouble for health and human rights, particularly regarding TB and MDR-TB. A close look at TB and MDR-TB within the exceptionally vulnerable population groups of migrants and prisoners highlights the pressing need for urgent intervention. But it also underscores the difficulty of taking a rights-based approach to TB in a country that denies rights to prisoners and migrants. Can North Korea, with its obvious challenges to human rights principles, address the underlying social and economic determinants of the disease? It is conceivable that the North Korean Ministry of Public Health could identify the benefit of widely distributing easy to understand information about TB, how it is contracted and how it should be treated. Circulating this information in Sino-Korean border areas and in re-education camps, detention centers, and prisons could alert people to cases of concern. International collaboration that stresses the importance of treating incarcerated and migrant groups, along with emphasizing the cost benefits of doing so, may persuade North Korea to take action.

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