There is no reliable information regarding air quality. Coal and coal dust bricks, used for heating, cause high levels of air pollution in densely inhabited areas. Chemical contamination from factories may be less important, considering the low level of industrial activity in the country.

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Supplement

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STATEMENT BY THE PRESIDENT OF THE SECURITY COUNCIL

At the 3451st meeting of the Security Council, held on 4 November 1994, in connection with the Council's consideration of the item entitled "Agreed Framework of 21 October 1994 between the United States of America and the Democratic People's Republic of Korea", the President of the Security Council made the following statement on behalf of the Council:

"The Security Council recalls the statements made by the President of the Council on 8 April 1993 (S/25562), 31 March 1994 (S/PRST/1994/13) and 30 May 1994 (S/PRST/1994/28) and its relevant resolution.

"The Security Council reaffirms the critical importance of International Atomic Energy Agency (IAEA) safeguards in the implementation of the Treaty on the Non-Proliferation of Nuclear Weapons (the Treaty) and the contribution which progress in non-proliferation makes to the maintenance of international peace and security.

"The Security Council notes with satisfaction the 'Agreed Framework between the United States of America and the Democratic People's Republic of Korea (DPRK)' (Agreed Framework) of 21 October 1994 as a positive step in the direction of denuclearizing the Korean Peninsula and maintaining peace and security in the region.

"The Security Council notes that the parties to the Agreed Framework

decided to (1) cooperate in replacing the DPRK's graphite-moderated reactors and related facilities with light-water reactor power plants, (2) move towards full normalization of political and economic relations, (3) work together for peace and security on a nuclear-free Korean Peninsula, and (4) work together to strengthen the international nuclear non-proliferation regime.

"The Security Council takes note of the decision of the DPRK in the Agreed Framework to remain a party to the Treaty on the Non-Proliferation of Nuclear Weapons. It notes also the DPRK's decision to come into full compliance with the IAEA-DPRK Safeguards Agreement (INFCIRC/403) under the Treaty.

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Health-relating Behavior of Migrants from DPRK

An Internal and Interim NGO Report

[INTERNAL REPORT: NOT FOR PUBLIC DISTRIBUTION]

Introduction

There is little available data on the health of North Koreans and the health system that serves them. Despite the country's reliance on international humanitarian aid for most of the last decade, the government has restricted access and prevented a comprehensive assessment of health systems.[1] In September 2005, in an initiative that can only isolate the country further, North Korean authorities announced that all foreign agencies must leave North Korea by the end of the year.[2] Despite the limited access, reports from NGOs; information from the World Health Organization, UNICEF, and other United Nations organizations; and surveys of North Koreans outside their country paint a picture of a health system in crisis.[3]

From its origin in the late 1940s, the Democratic People's Republic of Korea (DPRK) has concentrated on building a society based on "Juche" or self-reliance and one which has been largely isolated from the outside world. In 1989, with the collapse of its principle patron, the Soviet Union, the North Korean economy began to deteriorate. The natural disasters of the mid-1990s proved to be the tipping point, leading to wide-spread food shortages and an unprecedented request for external assistance. Some 3.6 million tons of food aid have been provided to North Korea since 1995.[4] However little monitoring of its distribution has been permitted by the DPRK authorities.[5] During the period 1996 and 1997 especially—the so-called "March through Hardship"—death rates rose, internal and external migration accelerated, and birth rates dropped.[6]

In the 1970s and 1980s, the DPRK paraded its health system as one of the best in the world. Article 72 of the DPRK constitution guarantees universal and free health care. An emphasis on equity expanded health services to rural and remote areas. With a population of 21 million, the DPRK lists 800 general and specialized hospitals at the higher administrative levels and 1000 hospitals and 6500 polyclinics at the lower administrative levels.[7] For all of DPRK there are said to be some 10,000 hospital beds. At lower administrative levels, *ri* in rural areas and *dong* in urban areas, there are clinics and "section doctors" that provide primary services at county hospitals. Although a referral system exists, serious shortage of transportation seems to have limited its use.

To staff the health system, for each 100,000 North Koreans, there are 180 nurses and 297 medical officers. The isolation of North Korea has cut off professional education from developments elsewhere in the world.[8] Doctors, along with others, have limited freedom of movement.[9] Continuing medical education seems not to be very widespread.

While some showcase health facilities exist in Pyongyang, elsewhere facilities are old, in poor repair, without water and electricity much of the time, and unheated in the harsh Korean winter.[10] Equipment is generally old, and sometimes dangerous to operators.[11] Supplies, reagents and spare parts often are missing. Some hospitals have reportedly started to grow their own cotton for dressings.[12] Perhaps the most critical shortage is that of medicines. This is a widespread problem, and visitors to the country are often requested to bring gifts of medicines.

Among diseases, hepatitis B and tuberculosis are reportedly common, with 40,000 or more cased reported annually (10). Limited data on disease and injuries are reported outside the DPRK, and the validity of these numbers is uncertain but anecdotal reports indicate a high rate of injuries, often related to problems in the workplace. The periods of famine and chronic nutritional deficiencies may have debilitated sections of the populations. There are widespread reports of medicines sold in the open market, and people resorting to traditional medicines to cope with illness.

To shed some light on care-seeking behavior of the North Korean population and the function of health facilities, we interviewed 273 North Koreans who had recently entered Yanbian Korean Autonomous Prefecture in Jilin Province, China to seek aid, work or refuge (see map). They were asked about illness, ambulatory treatment, hospitalizations, payment for care and their perceptions of health services while in North Korea. While this not a representative cross-section of the North Korean population, it does provides a glimpse into illness and medical treatment in DPRK.

Research Method

A series of questions were developed, tested and adapted through formative studies with North Koreans in China. Experienced Korean-Chinese interviewers were trained to ask questions and record data concerning care-seeking behavior. During the period January – June, 2004, newly arrived persons from North Korea were identified through an informal assistance network and asked to participate in the study. Persons in China for more than 30 days were excluded. The purpose of the study was explained to potential participants and they were provided an opportunity to give verbal, informed consent. Interviews were conducted in locations deemed to be safe by both interviewers and respondents. No unique identifiers of respondents were recorded, and no incentives provided. In all, 273 North Koreans met the selection criteria. Data were entered using EpiInfo v6 and analyzed with Stata.[1] The study was approved by the Committee on Human Research at Johns Hopkins Bloomberg School of Public Health.

Results

Demographic characteristics

Of the 273 respondents in the study, the median age was 40 yrs (IQR 35-45). There were 138 males (50.5%) and 135 females (49.5%). The vast majority (96%) had come to China from North

[1] Stata Corporation, College Station, Texas

Hamkyeong Province, which is directly across the Tumen River from China. Married persons composed 74.4% of the group, divorced 12.0%, single 9.9% and widowed 3.3%. Those under age 30 accounted for 11.4% of the sample, and those age 50 and older accounted for 11.4%. Rural residents made up 56% of North Korean respondents coming to China. Among rural residents, there were more persons in the older age groups. The average time in China at the time of the interview was 25 days (IQR 15-45). Employment, income and housing characteristics are shown in Table 1.

Household characteristics

For this study, the head of household was defined as the principal wage earner, or if both spouses were employed, the male. Among heads of household interviewed, 119 (43.6%) were male and 154 (56.4%) were female. All heads of household had at least a middle school education, with 20% having a college or university education. There was little difference in educational attainment between men and women. Over 75% of households reported at least one family member belonging to the Korean Worker's Party.

The median household monthly income was 7000 won for urban residents, and 6000 won for rural residents. Household incomes for female-headed households were similar to those of male-headed households. Eleven percent of persons interviewed came from households with a monthly income of less than 4000 won (at a market exchange rate of 2500 NK won per US$1.00, this amounts to US$1.60). Households headed by persons under age 30 had the lowest incomes, averaging 3826 won per month. The highest median monthly income (6283 won) was among households headed by someone aged 40-49 years. This was followed by households headed by those over 50 years. College and university graduates had higher household incomes than middle school graduates. The lowest household incomes were among households headed by farmers and miners.

Formal employment status for the household head is listed in Table 1. Sixty percent of people listed their official occupation as 'unemployed.' Of the unemployed category, 88.4% were women. Nearly all household heads had a secondary or unofficial job. The most common secondary jobs were retailing food items (21.3%) and manufacturing (19.1%).

Source of health care

Most respondents (66.8%) identified county hospitals as their nearest source of care, followed by the section doctors (28%) and clinics (5.2%). The median time to reach the nearest health facility by foot was 25 minutes (average was 29.8 minutes). This was essentially the same for both urban and rural areas. A visit to a health facility, including both waiting and consultation time, lasted about one hour (58.3 min) (IQR 25-91.6). The higher the household income, the shorter was the time spent.

Potential sources of treatment

Persons were asked where they would seek treatment if they had one of a list of seven conditions. The results are shown in Table 2. Generally, for conditions like cough, fever and diarrhea, where the diagnosis is straightforward, respondents overwhelmingly preferred going directly to the drug sellers for treatment. For potentially more complex conditions—including

tuberculosis, injury, mental illness and dental problems—the majority of respondents said they would use the county or provincial hospitals. There seemed to be little willingness to use the primary health care clinic or "section doctors". This may reflect a perceived shortage of drugs at this level or possibly a lower quality of care. Essentially no preference was given to traditional healers, although, for treatment of mental illness, about 10% of respondents stated a preference for treatment outside the hospital and clinic system and another 4.1% said they didn't know what sort of treatment they would seek.

Acute illnesses

The majority of respondents (78%) reported that someone in the household had been ill in the two weeks before the respondent had left North Korea. In 21.3% of cases, the patient had been under age 17. Sixty percent of the reported acute illnesses had been among females. Of the households with recent illnesses, 23.3% reported that the ill person had received treatment from a second location.

Among the most common conditions were diarrhea (39.3%), common cold (27.6%), fever (12.1%), indigestion (11.9%) and influenza (1.9%). When the diagnoses reported by respondents were classified by ICD-10 classification, infectious diseases accounted for 40.2 %, respiratory tract conditions for 31.3% digestive tract for 16%, and 27% were attributed to 'signs and symptoms," which included clinical or laboratory abnormalities without an obvious etiology.

Hospitalizations

Most households (88.3%) reported that a family member had been admitted to hospital in the year before the respondent crossed into China. The median age for outpatients was 17 years of age, and persons less than 17 years of age accounted for 46.7.3% of hospitalizations. Admissions for males and females were nearly equal. Forty-four percent of persons hospitalized had initially received treatment at another location. It is not possible to determine what proportion were formal referrals within the health system, and how many were self-referrals.

The most common hospital diagnoses reported were appendicitis (9.5%) injuries to the lower extremities (6.2%) hepatitis (5.8%), malnutrition (5.4%) and gastric complaints (4.1%). When classified by ICD-10 categories the digestive system accounted for 19.5% of admissions, infectious disease for 16.6%, injuries and poisoning for 17.0%, the genitourinary system for 9.5%, and the musculoskeletal system for 8.3%. Malnutrition accounted for 5.4% of admissions. The length of hospitalization averaged about 30 days.

Costs for hospitalizations

Although free health care is guaranteed by the North Korean constitution, unofficial payments were made to hospital doctors in over 90% of cases. Most households gave both cash and gifts such as cigarettes, alcohol, food, or clothes. The reason most commonly given for paying bribes to the doctor was in order to receive medicines.

The costs for both hospitalization and ambulatory care are shown in Table 3. The total costs of payments for both males and females rose with reported income. The median cost of hospitalizations for persons from households with incomes less than 2000 won per month was 1200 won, whereas hospitalizations from households earning 8000 won and above were paying a median cost of 8900 won for hospitalization of a male and 5200 won for hospitalization of a

female. For all income categories, the hospitalization costs for males usually exceeded costs for females.

Overall, costs were proportionate to the length of stay. For those who stayed beyond 35 days the hospital costs averaged in excess of 6000 won. Where the official employment was listed as mining, the hospitalization tended to be the longest. Among the patients whose hospitalizations costs were 5000 won or greater, malnutrition and hepatitis were the most common diagnoses.

Paying for health care

For ambulatory visits, 85.8% of respondents said they could meet costs for the visit out of money on hand. There were 11.2% who had to sell household items and 3.1% who had to borrow money to pay. The picture was much different with hospitalizations, where only 2.1% could meet costs out of pocket. Households had to sell household items in 77.5% of cases and borrow money in 20.4% to meet hospitalization costs.

Satisfaction with services

Respondents were asked about their satisfaction with various aspects of both inpatient and outpatient services they had received, using a five point scale from Very Dissatisfied to Dissatisfied to Mediocre to Satisfied to Very Satisfied. In no cases, were there more than 5% who were satisfied about any aspect of the health care they had received, and almost no one who was very satisfied with any aspect of their care. The exception was that 15% of persons were satisfied with their physical recovery from their illness. In general, the households from the lower socioeconomic strata were more likely to be the least satisfied with services. Courtesy, professional skills, x-ray services, medical equipment available, drug availability laboratory services were largely felt to be mediocre. Available supplies were unsatisfactory or very unsatisfactory to 89.1%; availability of personal needs was unsatisfactory/very unsatisfactory to 95.5%; waiting time unsatisfactory/very unsatisfactory to 87.2%; availability of electricity and water was unsatisfactory/very unsatisfactory to 99.6%; and general health facility cleanliness was unsatisfactory/very unsatisfactory to 92.9%.

Discussion

The picture emerging from these data is that of a health system in serious difficulty. While our respondents came mostly from North Hamkyeong, a province with 2.5 million of North Korea's 21 million population, there is some evidence that the health services are dysfunctional in other areas, with the possible exception of the showcase facilities in Pyongyang. The medical response to the train disaster of 22 April 2004, at Ryongchon station, for example, pointed out the poor response capacity of the health system.[13]

The median household income of 6641 won for the study sample represents US$2.66 a month using the unofficial exchange rate of $1=2500 obtaining at that time. The official rate was $US 1.00=170 won.[14] The fact that the highest incomes are occurring among households where the head of household lists his or her occupation as unemployed, suggests an informal economy is emerging. All respondents listed secondary occupations, the majority of which suggested informal sector activities.

Sources of care, either reported or preferred, suggests that the county hospitals rather than the section doctors or clinics are the preferred sites. This 'bypass' phenomenon could be linked to a shortage of drugs and supplies at lower levels, and a perception of low quality care. Indeed, the North Korean Ministry of Health has recently proposed an increase in doctors assigned to the *Ri* clinics to decrease the numbers of households covered by each section doctor.[15] The drug sellers are the preferred point of treatment for many of the ambulatory illnesses. In some cases the respondents were visiting drug sellers for self-treatment. It is also possible that diagnoses are made in the health facilities, but in the absence of drugs in facilities, patients turn to drug sellers for their treatment. This is a probable explanation for number of visits to health facilities, and the dissatisfaction reported for the availability of drugs and supplies. The proximity of North Hamkyeong to China and the special trade zone of Najin-Sonbong might mean that there are more drugs in the market here than in other parts of North Korea.

The chronic shortage of drugs in North Korean hospitals has been reported elsewhere.[16] It has been suggested that the amount of drugs being supplied to hospitals has been restricted to prevent hoarding by doctors.

The costs for inpatient care were major expenses for households. These costs were largely under-the-table payments to doctors. For households with low monthly income and for households of miners and agricultural workers, the costs of hospitalizations exceed their monthly income. A large proportion of household had to sell assets or borrow money to met costs. Yet this did not seem to limit the frequency of hospitalizations as 88% of households reported a hospitalization in the past year. This is consistent with other reports about hospital care in North Korea.[17] The nature of the condition requiring hospitalization may have been perceived to be so serious, that there where thought to be no alternatives to hospitalization. It is also possible that because of financial incentives from private payments to doctors there are unnecessary hospitalizations and surgical procedures. Keeping hospital beds full can be a protective administrative action in a centrally planned economy.

Although there were many reasons reported for hospitalization, the most common was for an appendectomy. This seems anomalous, as the frequency of acute appendicitis in most industrialized countries is seldom high. Removal of the appendix was followed in frequency by injuries to the lower extremities. The frequency of this diagnosis is consistent with the reports from NGOs, and may reflect risks from the deteriorating industrial state, and urban hazards (10). The reported average length of stay of 30 days far exceeds hospitalization in market economies but is consistent with hospitalization patterns in socialist countries.

The frequency of hospitalization for hepatitis is consistent with other information (10) and may be due to the reported breakdown of water and sanitation systems. The frequency of diarrhea in the past 2 weeks in 30% of all households is exceptionally high for an industrialized country, especially in winter months.

Not surprisingly, the satisfaction with health services is mediocre at best. The intense dissatisfaction with availability of water, electricity, hospital supplies, and personal services in hospitals is consistent with the poor state of the North Korean economy.

There are many limitations to this study. Our respondents were migrants who chose to endure the risks of leaving their own country without authorization, crossing a border guarded by security forces on both sides, and entering a country with an active deportation policy toward illegal North Koreans. Furthermore, almost all of the respondents came from North Hamkyeong which, given both its distance from the capital and its proximity to the Chinese border, makes it atypical as compared to other provinces.

Recall is also potential problem, probably less with hospitalizations than with ambulatory visits. This would apply particularly to diagnoses, wait time, and amounts paid. As migrants were interviewed within 90 days of their arrival in China, their responses would reflect a relatively recent condition.

Additionally, there is no baseline data or other source of information on health seeking behavior in North Korea against which these data could be compared.

Despite the limitations, the picture of health services and care-seeking behavior that emerges portrays a health system that is deteriorating and in flux. This is a system that is unable to meet the basic needs of its users. The system is unable to update equipment or provide necessary supplies. The population increasingly relies on drug-sellers as the principal source of supply. The bribes necessary to receive care in hospitals indicates deterioration in the integrity of health workers, and the ability of the health system to support them. Unfortunately, the largest burden of this failing health system falls on the poorest in society.

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Table 1. Key characteristics of the study population

Characteristic	Total n=273	Outpatient n=214	Inpatient n=241
Sex			
Male		85 (39.7)	124 (51.5)
Female		129 (60.3)	117 (48.6)
Age			
<17		100 (46.7)	51 (21.3)
17-54		103 (48.1)	157 (65.4)
>54		11(5.1)	32 (13.3)
Monthly Household Income, won			
<2000	15 (5.5)	6 (2.8)	6 (2.5)
2000-3999	15 (5.5)	10 (4.7)	11 (4.6)
4000-5999	64 (23.6)	41 (19.3)	58 (24.3)
6000-7999	140 (51.7)	129 (60.6)	134 (56.1)
8000+	37 (13.7)	27 (12.7)	30 (12.6)
Type of residence			
Urban	121 (44.3)	101 (47.2)	110 (45.6)
Rural	152 (55.7)	113 (52.8)	131 (54.4)
House Size, square meters			
Less than 20	47 (17.2)	22 (10.3)	34 (14.1)
20-29	130 (47.6)	110 (51.4)	115 (47.7)
Greater than 30	96 (35.2)	82 (38.3)	92 (38.2)
Official Employment			
Official worker	1 (0.37)	0	1 (0.4)
Factory worker	78 (28.6)	64 (29.9)	65 (27.0)
Farmer/Agriculture	14 (5.1)	8 (3.7)	9 (3.7)
Miner	16 (5.9)	11 (5.1)	12 (5.0)
Unemployed	164 (60.1)	131 (61.2)	154 (63.9)
Secondary work			
Agriculture	25 (9.2)	19 (8.9)	22 (9.1)
Grain	13(4.8)	11 (5.1)	11 (4.6)
Grocery	58 (21.3)	45 (21.0)	54 (22.4)
Firewood/coal	13 (4.8)	8 (3.7)	11 (4.6)
Manufacturing	52 (19.1)	40 (18.7)	51 (21.2)
Handicraft	18 (6.6)	16 (7.5)	17 (7.1)
Other business	20 (7.3)	16 (7.5)	13 (5.4)
Services	13 (4.8)	11 (5.1)	12 (5.0)
Mending/repair	28 (10.3)	26 (12.2)	26 (10.8)
Public Distribution (food)	27 (9.9)	17 (7.9)	19 (7.9)
Others	6 (2.2)	5 (2.3)	5 (2.1)
Korean Worker's Party membership			
Member	207 (76.7)	169 (79.3)	191 (79.9)
Non-member	63 (23.3)	44 (20.7)	48 (20.1)
Cost of illness, median (IQR), won		150 (100-250)	4000 (3500-5000)
Length of service, median (IQR), days		4 (3-7)	25 (20-30)

Table 2. potential sources of treatment for 7 possible conditions given by respondents (%)							
Condition	**Drug seller**	**Clinic/section doctor**	**County Hospital**	**Provincial Hospital**	**Traditional Healer**	**Others**	**Don't know**
Cough	249 (91.9)	9 (3.3)	9 (3.3)			4 (1.5)	
Fever	240 (88.6)	11 (4.1)	17 (6.3)			3 (1.1)	
Diarrhea	250 (92.3)	11 (4.1)	7 (2.6)			3 (1.1)	
TB	21 (7.8)	3 (1.1)	237 (87.5)	7 (2.6)		3 (1.1)	
Injury			114 (42.1)	154 (56.8)		3 (1.1)	
Mental		2 (0.7)	228 (84.1)	3 (1.1)	4 (1.5)	23 (8.5)	11 (4.1)
Dental	1 (0.4)	6 (2.2)	260 (95.9)			3 (1.1)	1 (0.4)

Table 3 Costs of hospitalization and ambulatory treatment by occupation, income group and proportion of household income.										
	Monthly HH income		Cost of hospitalization				Cost of ambulatory treatment			
Occupation	Median HH income	Mean HH income	Median HH costs	Proportion monthly HH income spent	Mean HH costs	Proportion monthly HH income spent	Median HH costs	Proportion monthly HH income spent	Mean HH costs	Proportion monthly HH income spent
Official worker	5000	5000	4000	0.80	4000	0.80	0	0.00	0	0.00
Factory worker	6500	6297	4000	0.62	4914	0.78	150	0.02	1551	0.25
Farmer / agriculture	2750	4036	4000	1.46	6584	1.63	175	0.06	5763	1.43
Miner	4500	4850	5250	1.17	5958	1.23	125	0.03	115	0.02
Unemployed	6500	6030	4000	0.62	4779	0.79	150	0.0	531	0.09
Income group										
<2000	1000	1148	1000	1.00	1183	1.03	0	0.00	80	0.07
2000-3999	2500	2600	4000	1.60	3564	1.37	200	0.08	1939	0.75
4000-5999	5000	4769	4000	0.80	4857	1.02	100	0.02	1465	0.31
6000-7999	6500	6629	4500	0.69	4759	0.72	150	0.02	408	0.06
>7999	8000	8581	4900	0.61	7167	0.84	300	0.04	3154	0.37


Yanbian
China
North
Hamkyang
South Hamkyang
Sea of Japan
Yellow
Sea
Pyongyang
North Korea
Demilitarized zone
South Korea
Seoul

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アジアにおけるHIV/AIDSがわが国に及ぼす影響

劒　陽子
産業医科大学医学部公衆衛生

はじめに

1981年にアメリカ国立防疫センター（CDC）によってロサンジェルス近郊における若い男性5例のカリニ肺炎という、世界で最初のエイズの症例が報告され、さらに1982年にエイズ（acquired immunodeficiency syndrome）と命名されて以来、HIV/AIDSは世界中で猛威を振るい続けており、アフリカの一部では国の存続を脅かすほどの問題になっている。

国連合同エイズ計画（UNAIDS）および世界保健機関（WHO）の2004年11月23日発表の報告[1]によると、2004年、全世界のHIVとともに生きる人びとの数は3,940万人（3,590～4,430万人）と推測され、過去最高の水準に達している。

最初の報告から20年以上が過ぎた現在、世界はすでにHIV/AIDS対策の重要性を認識しており、アジア各国でも様々な対策がとられている。それでも感染の拡大が留まる様子はない。感染の拡大が最も深刻なのはサハラ以南のアフリカであるが、アジア地域もサハラ以南アフリカに次いでHIV/AIDSが流行している地域である。わが国のHIV感染率は世界の中では非常に低率なものに留まってはいるものの、アジア地域に位置する一国として、HIV/AIDSの流行に無関心でいるわけにはいかない状況にある。本稿では、アジア及びわが国におけるHIV/AIDSの現状から、アジアにおけるHIV/AIDSの流行とわが国との関係について考えてみたいと思う。

1．アジアにおけるHIV/AIDSの状況

アジアでのHIVの流行は1980年代末にタイから始まったと言われている。そしてカンボジアなど周辺諸国に流行は拡大して行き、2000年前後にはアジア全域

に到達したとみられている。アジア諸国の中には、世界でもまだ数少ないHIV/AIDS 対策に成功したとされている国が存在しているものの、今でもアジア全体での流行は拡大し続けている。

UNAIDS/WHO の最新の推計[1]によれば、2004 年末に約 820 万人（540～1,180 万人）の HIV 感染者がアジアに存在し、年間の新規感染者数は 120 万人である。成人 HIV 陽性率は 0.4(0.3～0.6%)である。HIV 感染「率」だけをみると、アフリカなどに比較すると低いが、アジア諸国はアフリカと異なり、非常に多くの人口を抱えているということに注目しなくてはならない。つまり「率」は低くても感染者「数」は非常に多いのである。

また、一口にアジア地域と言っても、たくさんの国があり社会的・宗教的背景も異なっているが、HIV/AIDS の流行もその程度や特徴など国によってかなり差が認められる[2)3)]。

＊ HIV/エイズ対策に成功し、現在は流行が抑制されている国 - タイ、カンボジア

アジアでの HIV 流行の初期から流行に見舞われたものの、その対策が成功し現在では流行が抑制されている国として知られているのがタイとカンボジアである。これら 2 カ国では政府の強力な主導の下に、十分な数の国民をカバーできるように、中途半端ではなく、大規模な HIV/AIDS 対策を、特に対策を最も必要としているハイリスクグループの人びとをターゲットにして実施したことが功を奏した。タイでは国家レベルでの「100%コンドーム運動」を展開した結果、HIV 感染率は下がってきている。カンボジアでも同様の対策を行った結果、性風俗産業を利用する男性の数が減少し、性風俗産業でのコンドーム使用率が大きく上昇した。

さらに性感染症の急激な減少と HIV 感染率の安定した低下が認められるようになった。

＊ ハイリスクグループで流行が急増している国 － 中国、インドネシア、ネパール、ベトナム

中国、インドネシア、ネパール、ベトナムでは、今までは感染率が比較的低率に抑えられてきたものの、最近になってハイリスクグループの間で感染が急増している。ハイリスクグループの人びとが、現在でも感染の危険の高い行動をとり

続けているためである。「感染の危険の高い行動」とは、静脈注射薬物乱用者では針の使いまわしであり、性風俗産業従事者や男性同性愛者ではコンドームを使用しない性行為である。このまま効果的な対策がとられることがなければ、感染はさらに非ハイリスクグループの間にも蔓延していく危険がある。

＊ 感染リスクの低い集団にも HIV が浸透し、高い感染率が維持されている国－インド、ミャンマー、中国南西部

インド、ミャンマー、中国南西部では、HIV の流行が始まっているのにも関わらず適切な対策がとられなかったために、それまでハイリスクグループの人たちの間でのみほぼ留まっていた HIV の流行が、ハイリスクグループのパートナーなど、一般住民の間にも感染が広まってしまっている。これらの国では、対策が行われても短期的で、散漫であったことが感染の拡大につながったと考えられている。

＊ HIV 感染率が極めて低く保たれている国－バングラデシュ、フィリピン、ラオス、パキスタン、東チモール

アジアの中には、ハイリスクグループの間でも、依然感染率が低いままに保たれている国もある。そのような国の１つであるバングラデシュやフィリピンは HIV の流行が始まる前に、ハイリスク行動をとる人びとに対して何らかの予防サービスを提供していたため、流行が爆発するのを抑えているのではないかと言われている。これらの国では HIV の流行を阻止するための対策を今後も継続、拡充していく必要がある。また感染率が低いままに保たれているもののとりたてて対策を講じていない国もあり、今後の動向はまだまだ安心できない。

現在のところアジアにおける HIV/AIDS の流行はアフリカほどではないが、しかし全体として増加傾向にありしかもそのスピードが速い。しかし、アジアには世界でも数少ないエイズ対策に成功しつつある国がタイ、カンボジアの 2 カ国もある。アジアでの HIV/AIDS 流行をとどめることができるかどうかによって、世界におけるエイズ対策が成功するかどうかが左右されるといっても過言ではないであろう。

2．わが国における HIV/AIDS の状況

厚生労働省エイズ発生動向委員会の平成 15 年度エイズ発生動向[4]によると、1985 年～2003 年までのわが国における累計報告数は HIV 感染者数（AIDS 未発症者）が 5,780 人、AIDS 患者が 2,892 人であり（血液凝固製剤による感染者 1,432 名を除く）、日本における HIV 感染者数、AIDS 患者数は諸外国に比べると非常に少ない。しかし、2004 年に国内で新たに報告された HIV 感染者は 748 人、AIDS 患者は 366 人、計 1,114 人となり、報告制度が始まって以来、初めて 1000 人を超え、2004 年末までの累計 HIV 感染者数及び AIDS 患者数は 9,784 人となった。感染経路としては、性的接触によるものが約 8 割を占めて最も多く、特に近年では同性間性的接触による感染が急増してきている。性別では日本国籍男性の増加が顕著である。また年齢分布に注目してみると 20 代の HIV 感染者や AIDS 患者（つまり 10 代で感染したものと思われる）の報告が増加しており、特に若年者の間での流行が拡大してきていることが非常に懸念されている。静脈注射薬物乱用や母子感染によるものは現在では 1%以下と少ないが、特に静脈注射薬物乱用による感染者報告数はじわじわと増加傾向にある。

このように、わが国では新たに発見される HIV 感染者数も、AIDS 患者も増加の一途をたどっている。そして、献血血液の HIV 抗体陽性率も年々増加がみられている。報告される HIV 感染者数および AIDS 患者数というのは、検査を受けて発見された人数であるから、検査を受けずにいる潜在的な感染者数は報告されている数をはるかに上回ると考えられる。UNAIDS の 2003 年末の推計では[5]、日本には 12,000 人（5,700～1,9000 人）の感染者が存在していると言われている。その 3 分の 1、2,900 人（1,400～4,800 人）が女性である。

ちなみに他の先進諸国ではこれまでの対策が効を奏して、新たな感染者数は横ばいの状態であることが多く、また治療薬が進歩し、AIDS を発症する前に治療を開始する感染者が増えたために、AIDS 患者数は激減している。これらのことから考えると、わが国でこれまで行われてきた対策は効を奏しておらず、そのため早期発見・早期治療ができていないと言うことができる[6)-9)]。先進諸国の一員として、ODA や NGO などの活動で発展途上国における HIV/AIDS 対策に数多く関わってきているわが国であるが、自国の対策には十分に手が回っていないのである。

ちなみに、わが国における現在のエイズ対策の骨子は以下のとおりである[10)11)]。

＊ 医療体制の充実

エイズ診療の拠点となる病院を各都道府県に整備し、また全国８ブロックにはエイズ医療の水準の向上、地域格差の是正を目的としてブロック拠点病院を整備している。しかし、患者の多い地域では拠点病院が患者を受けきれなくなっており、また差別・偏見が解消されていない現状では、自分の病気が周囲にわかってしまうことを恐れて、わざわざ居住地域外の遠い病院まで通っているという患者も少なくない。

＊ 相談・指導・検査体制の充実

保健所で、プライバシーに配慮した相談窓口の設置や、無料・匿名のHIV抗体検査が実施されている。しかしこの保健所における無料・匿名検査は一般の人にはそれほど周知されておらず、また時間的にも制限のある所が多く（週一回平日午前のみなど)、それほど活用されていないのが現実であろう。

＊ 研究および国際協力の推進

エイズ研究拠点として国立感染症研究所内にエイズ研究センターが設置されている。国立国際医療センター内にもエイズ治療・研究開発センターが設置され、最新の医療を提供するほかに診断･治療法開発のための臨床研究などが行われている。またいくつかの機関では、アジア地域のエイズ専門家の研修など国際協力も支援している。

＊ 正しい知識の普及・啓発

政府広報、メディア、地域、職域などにおける啓発活動、海外渡航者に対する空港でのビデオによるPR作戦などが展開されているようであるが､国民の間に十分に知識が普及しているとは言い難い状況である。また学校教育の場は、HIV/AIDSに関する教育を行うのに適当な場所であるといえるが、学校でのエイズ教育は人権教育の側面のみに偏りがちであり、HIV/AIDSを自分の問題としてとらえ、予防行動をとれるようになるための性教育的な側面でのエイズ教育は不十分である。このことは、いくつかの若者を対象とした性行動・性意識調査での、「エイズはトイレや電車のつり革ではうつらない。正しいか誤りか。」というような差別・偏見の助長に関する質問は正答率が高いのに比し、どうやってHIV感染を予防することができるかということに関する具体的な質問（「性感染症にかかっ