MICSUN XI

Background Guide

April 9-10th, 2021

World Health Organization (WHO)

Dear Delegates,

Welcome to the 9th iteration of the Miami International Conference for the Simulation of the United Nations (MICSUN) for 2021. My name is Laura Bea and it is my pleasure to be your Chair for the World Health Organization and Chief of Staff for this year's conference. On behalf of myself, the staff, and the rest of the Secretariat, I want to personally thank you for joining me especially during these challenging times. I know all delegates have put a great amount of effort into writing their position papers, researching, and preparing for lively debate. I am excited to hear delegate debate on real-world issues and relevant dilemmas around health disparities in minority communities and the black market influence of medicine.

I am currently an undergraduate student at the University of Miami, majoring in political science, with a minor in Journalism, and concentrations in Latin American history and anthropology. I have been involved in Model United Nations for around three years now, and I have the honor of being able to chair one of my personal favorite committees. MICSUN is always an incredible experience for delegates and staff alike, and I am so excited to see what this year has in store for us. When I am not doing Model UN, spending time with my family, or drinking coffee!

For this committee, a **position paper is required** and must be submitted by the beginning of the first committee session. Your position papers should address the country's stance on the given topic, a background to the issues provided, the country's current stance, and your suggested recommendations for solutions to the issues we will be discussing throughout the course of the weekend.

If you have any questions or concerns, please do not hesitate to reach out to me. I would be happy to answer any of your questions and clarify any doubts. Good luck, delegates. I look forward to seeing you all (virtually) soon!

Best,

Laura Bea
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Director, World Health Organization

Dear Delegates,

Welcome to the ninth session of the Miami International Conference for the Simulation of the United Nations (MICSUN) for 2021. My name is Niloy Bhattacharyya and it is my honor to be your Chair for the World Health Organization for this year's conference. It has been my pleasure to be working with the staff, and the Secretariat and I am very much looking forward to working with you all during the conference. I would sincerely like to thank each one of you all for attending this conference, particularly during the unprecedented times that we are all living in. It demonstrates a true sense of dedication and diligence. I am sure that each delegate present has dedicated their valuable time and effort into the preparation of this conference, including writing their position papers, researching, originating discussion for debate, and for forming resolutions to such important issues. I would like to thank all of you very much for your preparation and for your commitment and am looking forward to hearing your ideas and your innovative resolutions to the issues that will be discussed.

I am a freshman at the University of Miami majoring in Biology and minoring in Chemistry and Music. I have lived in several states within the United States and in different islands within the Caribbean, and this has contributed to my passion for international relations and appreciation for diversity. I have been a member of Model United Nations for approximately three years now and have grown an appreciation for the art of debate and negotiation. Outside of Model UN I am a part of the performing arts group at the university as a vocalist and an actor, an Orientation Fellow, and a First Year Fellow. Besides being a part of these organizations, my hobbies include travelling, hiking, and being with friends and family.

For this committee, each delegation must have submitted a position paper prior to the opening of debate. Your position papers must include a background and context to the issues that are at hand, the country's stance, and your suggested recommendations for solutions to the topic and matters that will be debated upon throughout the course of the conference.

Best of luck to each and every one of you. I am excited to see you all at the conference soon.

Warm regards,

Niloy Bandyopadhyay Bhattacharyya
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Director, World Health Organization

The World Health Organization

The World Health Organization, or WHO, is a General Assembly committee within the United Nations that seeks to distribute proper information regarding public health, advise practitioners and researchers, and support the health of all individuals, particularly among underprivileged communities. The World Health Organization was specifically established in 1948 "to coordinate health affairs within the United Nations System"[1]. When the organization was initially formed, the original objectives were to provide alleviation of infectious diseases, represent issues in the health of women and children, address issues of sanitation, and more. Today, the WHO advises 194 member nations on the potential spaces for solutions and has continuously expanded their coverage of health-related topics.

Many of the greatest public health advances of the past century have occurred under the guidance of the World Health Organization, including the eradication of diseases such as smallpox, the near eradication of polio, and the management of the 2009 H1N1 outbreak. In the present day, the organization continues to advocate for the health of disadvantaged populations, including health disparities in minorities and underprivileged communities. One of the major health issues that the World Health Organization is focusing on currently is the COVID-19 pandemic, which has been caused by the novel coronavirus that originated in 2019. Due to the pandemic, threats to public health, and healthcare disparities have been exemplified, derived from different rates of "prevalence, mortality, burden of disease[2]" and a variety of other factors that lead to health inequality among different demographic groups. During this time, the organization coordinates the worldwide response to the COVID-19 pandemic and advises on methods on how to treat patients who are suffering from the effects of the pandemic, and how to decrease the spread of the pandemic, in regions of varying demographic and socioeconomic statuses internationally.

[1] Brief History of WHO." *Brief History of WHO | Credible Voice: WHO-Beijing and the SARS Crisis*, Columbia University, 2021, ccnmtl.columbia.edu/projects/caseconsortium/casestudies/112/casestudy/www/layout/case_id_112_id_776.html#:~:text=The%20World%20Health%20Organization%20was,children's%20health%2C%20nutrition%20and%20sanitation.

[2] Sciences, National Academies of, et al. "The State of Health Disparities in the United States." *Communities in Action: Pathways to Health Equity.*, U.S. National Library of Medicine, 11 Jan. 2017, www.ncbi.nlm.nih.gov/books/NBK425844/.

Topic One: Health Disparities in Minority Communities

Introduction

Health disparities refer to the inequalities that exist in provisions of healthcare and accessibility thereof, across distinct social, racial, ethnic, political, and socioeconomic lines.[3]

Dating back to 1840, theories on health inequalities were brought to fruition, introducing the international sphere to a crucial linkage between socialization and health. Among such developments was British statistician Edwin Chadwick's discovery of significant differences in mortality rates among groups of differing social, racial and political classes. In the 20th century, studies into the socialization of medicine and healthcare in differing communities gained greater prevalence, and the specific study of class, ethnic and racial differences in health status took the medical atmosphere by storm. To illustrate, this study of linkage led European scientists to both assert and confirm theories that argued that almost half of the British mortality rate for infants was absolutely avoidable if the social circumstances found in wealthier communities were mirrored in poorer communities. [4] Now, in the 21st century, health disparities and inequalities have been attributed to multiple variables, and social determinants of mental health, exposure to illness, diseases, preventative care, and more continue to impact men and women in almost all regions of the world. [5]

Socioeconomic Impacts

Health disparities greatly vary among different socioeconomic factors, including education and income. With education, access to healthcare is often divided between educational experience and opportunity. For example, "among adults, 40 percent of those who have not graduated from high school are uninsured, compared with only 10 percent of college graduates; more than 60 percent of the uninsured are in low-income families." [6] These disparities are generally common in countries where educational divisions between classes are high. Even in countries like the United Kingdom, where universal coverage is a pillar of their healthcare system, those individuals with less educational experience are subject to higher costs in healthcare services, and thus do not have access to all healthcare services needed for diseases, illnesses and more.

These disparities especially stem as a consequence of strict income divisions within global communities. Recent studies have shown that lower rates of income are more associated with higher rates of mortality. According to the University of Miami Miller School of Medicine, "although controversial, one explanation is that underinvestment in public goods and welfare and the experience of inequality are both greater in more stratified societies and that these, in turn, affect health." [7]

Due to the healthcare system in place within the United States, the large divisions of wealth between the upper, middle, and lower classes have consequences on mortality among families and children, especially because lower-income families avoid paying insurance fees and costs of healthcare if they surpass the income flow the household is receiving. Thus, direct correlations show us that diseases, illnesses, cancer, etc. are more prevalent among lower-income communities, as they are unable to afford preventive treatment and care, both in the short and long run.

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[3] Mandal, Dr. Ananya. "What Are Health Disparities?" *News*, News-Medical.net, 27 Feb. 2019, www.news-medical.net/health/What-are-Health-Disparities.aspx.

4 Gibbons, Michael C. "A Historical Overview of Health Disparities and the Potential of EHealth Solutions." Journal of Medical Internet Research, Gunther Eysenbach, 4 Oct. 2005, www.ncbi.nlm.nih.gov/pmc/articles/PMC1550690/.

5 Oberg, Charles, et al. "Child Health Disparities in the 21st Century." Current Problems in Pediatric and Adolescent Health Care, U.S. National Library of Medicine, Sept. 2016, pubmed.ncbi.nlm.nih.gov/27712646/.

6 "Brief History of WHO." Brief History of WHO | Credible Voice: WHO-Beijing and the SARS Crisis, Columbia University , 2021, ccnmtl.columbia.edu/projects/caseconsortium/casestudies/112/casestudy/www/layout/case_id_112_id_776.html#:~:text=The%20World%20Health%20Organization%20was,children's%20health%2C%20nutrition%20and%20sanitation.

7 Adler, Nancy E., and Katherine Newman. "Socioeconomic Disparities In Health: Pathways And Policies: Health Affairs Journal." Health Affairs, Apr. 2002, www.healthaffairs.org/doi/10.1377/hlthaff.21.2.60.

Sociocultural Influences

Among different social and cultural groups, health disparities are prevalent among minority communities that have been subject to acculturation. As defined by the US National Library of Medicine National Institutes of health, acculturation is "typically used to explain ethnic disparities in health outcomes and is based on the assumption that culturally based knowledge, attitudes, and beliefs cause people to behave in certain ways and make specific health choices"[8] By dividing "mainstream" culture from "nontraditional" culture, many ethnic, and minority groups are subject to health discrimination because of individual beliefs and attitudes about certain cultural preference, practices, and traditions. For example, the African American population within the US has a different cultural environment than African Americans in the Caribbean or in Africa. Differences in cultural values and traditions are often overlooked by healthcare systems, because of an inherent belief towards "preserving unity and purity" within an advanced institution. Thus, specific cultural practices are often unaccounted for, and further exclude many groups and communities from specific access to resources and medicines that are usually prevalent in more localized systems of health, and not on a centralized, international scale.

Race and Ethnicity

Racial discrimination — whether via political or economic instruments — has been a catalyst for health inequality across the international community. This has been demonstrated in many different nations due to segregation policies that undermine the healthcare of minorities and oppressed communities. One of the most prominent instances in history where this was seen was in the segregationist policies administered by South Africa throughout the 19th century. During this time period, many of the citizens of South Africa, who were not of European descent, experienced discriminatory practices that manifested into health inequalities across the nation. Further, early reviews into the research and study of the connection between race and health has found substantial relationships between discrimination and mortality. For example, Australia, the UK, Sweden, and other nations have reported seeing a striking pattern of increased health disparities among minority communities, such as African American and Asian Americans, specifically noting that these certain minority groups reported having more chronic illnesses, obesity rates, illicit drug use rates, and more. [9] Racial minorities in the international arena have been historically subject to discrimination, resulting in limited access to health resources and services and possibilities for treatment and care. Today, polarized debates around clashing policies of healthcare have made health disparities among different racial and ethnic communities even more prevalent than before.

Religious Discrimination

Faith and religious identity have been a crucial variable when considering health disparities in both developed and developing countries; often stemming from intentional socioeconomic marginalization of certain groups as well as the failure to accommodate religious practices into the elaboration of public health programs and healthcare systems. For example, in the United States, the consequences of health disparities are best exemplified in the health standards of Muslim Americans -- which most notably derived from their religious practices and traditions, often subject to neglect within the healthcare sphere. As a part of their religious ideals, Muslim Americans partake in the traditional practice of fasting during the month of Ramadan. Over the years, the study of risk factors among Muslim Americans have shown that members with pre-existing health conditions such as chronic illness and obesity may be endangered by this tradition. Many licensed doctors and scientists have asserted that the practice of fasting factors into the high morbidity rate found in the Muslim population, seeing as the tradition often complicates nutrition, diet, and sleep schedules that are significant to the prevention and management of diseases and

8 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1924616/

9 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2821669/

chronic illnesses.[10] Within the healthcare sphere, Muslim Americans are often subject to discrimination, in part because their religious practices are seen by some as foreign to US religious traditions and are subject to strict scrutiny with regard to the accessibility of medicine and preventive treatments for diseases, illnesses and more.

In the international sphere, health disparities are notably seen in Middle Eastern, Asian, and African communities. In a 2008 study done by India's Third District Level Household Survey, results revealed that, "higher proportions of Muslims and Christians in a community lower the odds of receiving BCG (bacille Calmette-Guerin) vaccines and seeking child healthcare and households residing in communities with higher levels of religious minorities in India experience worse child survival."[11] These disparities are consequences of discrimination faced by minorities through the accessibility of resources and the environmental factors that surround their communities. While the average, individual life for a Muslim or Christian minority in India is somewhat comfortable, community characteristics show us otherwise. Communities with high Christian or Muslim populations in India report having high rates of diseases, illnesses, and more, in part because they have higher inaccessibility rates to safe facilities, clean water, adequate healthcare policies, informative healthcare education, and health centralization.

Political Affiliations

Healthcare disparities are also prevalent in communities where political minorities exist under opposing predominant political spheres of influences. For example, conservative groups of individuals that reside in predominantly liberal communities are often discriminated against, especially due to their opposition to the Patient and Protection Affordable Care Act[12], passed in 2010 under US President Obama's administration. Likewise, liberal groups that reside in predominantly conservative communities are discriminated against due to their support of expansionist policies and universal healthcare. These discriminatory practices often result in the strict scrutiny of doctors and physicians when it comes to providing medical services. Given the tense, political atmosphere in both the international and domestic arena, health disparities are often prevalent in hyper-polarized situations of politics, and result in the intense limitations of healthcare policies and accessibility of medicine, both on the local, state, federal and global level.

Current Situation and Committee Structure

Currently, health disparities are ravaging communities and citizens across the group. From developed to developing nations, these disparities are hurting healthcare systems' effectiveness to provide for its citizens and to uphold public health. This committee will be focused on addressing the different factors that make up the debate around the socialization of health disparities, specific to minority communities. Whether that be religious, political, socioeconomic, racial, ethnic, or more, all countries must work together to revamp healthcare systems across the globe, address the causes and effects of healthcare disparities, terminate minority discrimination in healthcare spheres, and work to establish solutions that prevent further inequality from existing within all healthcare systems and institutions.

Questions Resolutions Must Consider

1. How can you accommodate cultural and religious practices, while ensuring equal healthcare across different groups?
2. How does discrimination factor into the accessibility and inaccessibility of medicine and healthcare in both developed and developing nations?

10 Laird, Lance D., et al. "Muslim Patients and Health Disparities in the UK and the US." Archives of Disease in Childhood, BMJ Group, Oct. 2007, www.ncbi.nlm.nih.gov/pmc/articles/PMC2083249/.

11 World Bank Malaysia Office, Level 3, Sasana Kijang, No. 2, Jalan Dato' Onn. "Disparities in Child Mortality among Religious Minorities in the Districts of India." World Bank, The World Bank, 29 Mar. 2018, www.worldbank.org/en/events/2018/03/29/disparities-in-child-mortality-among-religious-minorities-in-the-districts-of-india.

12 "Patient Protection and Affordable Care Act - HealthCare.gov Glossary." HealthCare.gov, 2010, www.healthcare.gov/glossary/patient-protection-and-affordable-care-act/.

3. How have governments and healthcare institutions restricted access to advanced healthcare policies and provisions?
4. How can we address the underlying causes of discrimination against minority communities in the healthcare and public health sphere?
5. How do demographics and socialization play a role in health disparities across the globe?
6. Why is it significant to analyze health disparities within minority communities, and what does it say about political, economic, and social international policy?
7. How does political and economic development affect public opinion and agenda setting about healthcare in both developed and developing nations?
8. How can we improve and alleviate healthcare disparities in underserved populations?
9. How can education and income, as well as political, racial, and cultural divisions, expand or limit healthcare disparities among different minority communities?

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5. Oberg, Charles, et al. "Child Health Disparities in the 21st Century." *Current Problems in Pediatric and Adolescent Health Care*, U.S. National Library of Medicine, Sept. 2016, pubmed.ncbi.nlm.nih.gov/27712646/.
6. "Brief History of WHO." *Brief History of WHO | Credible Voice: WHO-Beijing and the SARS Crisis*, Columbia University , 2021, ccnmtl.columbia.edu/projects/caseconsortium/casestudies/112/casestudy/www/layout/case_id_112_id_776.html#:~:text=The%20World%20Health%20Organization%20was,children's%20health%2C%20nutrition%20and%20sanitation.
7. Adler, Nancy E., and Katherine Newman. "Socioeconomic Disparities In Health: Pathways And Policies: Health Affairs Journal." *Health Affairs*, Apr. 2002, www.healthaffairs.org/doi/10.1377/hlthaff.21.2.60.
8. Laird, Lance D., et al. "Muslim Patients and Health Disparities in the UK and the US." *Archives of Disease in Childhood*, BMJ Group, Oct. 2007, www.ncbi.nlm.nih.gov/pmc/articles/PMC2083249/.
9. World Bank Malaysia Office. "Disparities in Child Mortality among Religious Minorities in the Districts of India." *World Bank*, The World Bank, 29 Mar. 2018,

www.worldbank.org/en/events/2018/03/29/disparities-in-child-mortality-among-religious-minorities-in-the-districts-of-india.

10. "Patient Protection and Affordable Care Act - HealthCare.gov Glossary." *HealthCare.gov*, 2010, www.healthcare.gov/glossary/patient-protection-and-affordable-care-act/.

Topic Two: Preventing Black Market Influence in Medicine

Introduction

The black market refers to an intricate system of economic trade that occurs in illegal forms. It is prevalent internationally and has a vast influence in a variety of economies, and most notably in healthcare. It is commonly defined as a system of purchasing and selling goods and services through methods that are prohibited by laws and regulations that are meant to protect consumers and businesses alike. These violations can include the marketing of illegal goods and services, the void of paying taxes, and "official rates of exchange among currencies". [13] The term "black market" was coined in 1939, during the second World War, and has grown over the past century, gaining influence internationally. [14] There are a variety of components within the infrastructure of healthcare that are influenced by the black market. One of the most prominent issues within the sphere of healthcare would be the illegal purchasing of medical drugs, equipment, and supplies. More specifically, the field of illicit trade of medicinal drugs has increasingly become more common among developing and developed countries over the last few years. With its presence, increasing prices of medicinal drugs have resulted and economic, medicinal, social, and security repercussions have been exacerbated, significantly impacting the welfare of both individuals and the state at large.

Counterfeit Medicinal Drugs

Within the jurisdiction of the black market, contraband and counterfeit medical drugs are significant issues within the developing healthcare spheres. According to the US Pharmacist, counterfeit drugs are defined as "products deliberately and fraudulently produced and/or mislabeled with respect to identity and/or source to make it appear to be a genuine product"[15] Today, counterfeit drugs comprise an increasing percentage of the drug market, especially in developing countries. The WHO estimates that counterfeit medications make up as much as 30% of medicines sold in Asia, Africa, and Latin America. In Africa, these numbers are most notably seen in disease-controlling medications. For example, in 2011, 64% of antimalarial drugs in Nigeria were counterfeited. These numbers are even notable across the entire international arena. According to the US National Library of Medicine from the National Institutes of Health, "worldwide, an estimated 10% of all medicines are counterfeit." [16] Overall, antibiotics and anti-parasites are the most common classes of medications designated to be counterfeit in the world. Further, of these percentages, black market internet pharmacies are among the topmost significant contributors to counterfeit medicine and its presence in the international market. Other significant causes of the presence of counterfeit drugs in developing healthcare spheres is drug shortages and convoluted supply chains. According to Nursing for Women's Health: Public Health Implications of Counterfeit Medications, "a large portion of counterfeit medications are sold through online pharmacies and websites. According to estimates from the WHO, about 50% of all medications sold online are counterfeit (Johnston & Holt, 2014). Researchers from the United Kingdom documented that 25% of general practitioners who were surveyed reported they had cared for

[13] The Editors of Encyclopedia of Britannica. "Black Market." *Encyclopædia Britannica*, Encyclopædia Britannica, Inc., 2017, www.britannica.com/topic/black-market

[14] " Gale Library of Daily Life: American Civil War. . Encyclopedia.com. 11 Mar. 2021 ." *Encyclopedia.com*, Encyclopedia.com, 14 Mar. 2021, www.encyclopedia.com/social-sciences-and-law/law/crime-and-law-enforcement/black-market#:~:text=The%20term%20began%20to%20be,Europe%20and%20illegal%20trade%20flourished.

[15] Williams, LaKeisha. "The Real Impact of Counterfeit Medications." *U.S. Pharmacist – The Leading Journal in Pharmacy*, 19 June 2014, www.uspharmacist.com/article/counterfeit-meds.

[16] Blackstone, Erwin A., et al. "The Health and Economic Effects of Counterfeit Drugs." *American Health & Drug Benefits*, Engage Healthcare Communications, LLC, June 2014, www.ncbi.nlm.nih.gov/pmc/articles/PMC4105729/.

individuals who had experienced adverse effects from medications ordered online." [17]

Within the debates around counterfeit medicine is the disturbing and significant effect that results from the presence of counterfeit drugs in the international market. Counterfeit medicine has, over time, proven to result in threatening health disparities and issues across differing communities in the world, as well as pose serious economic impacts abroad.

Health Effects of Counterfeit Medicine

Counterfeit medicine can negatively impact health in individuals in a variety of ways. For example, according to Nursing for Women's Health: Public Health Implications of Counterfeit Medications, "a decreased concentration or altogether absence of the active pharmaceutical ingredient of a drug can prevent an individual's condition from improving and potentially lead to death as a result. In the case of antibiotics, a less-than-therapeutic concentration of the active pharmaceutical ingredient can fail to resolve an infection and can contribute to antibiotic resistance. When a treatment appears to fail, a health care provider may then prescribe a different, more broad-spectrum antibiotic, which can further contribute to antibiotic resistance (Johnston & Holt, 2014)." [18] This resistance, and the combination of minimized improvement in any health condition, can decrease an individual's ability to surpass health difficulties in the long run, and even be more subject to life-threatening situations, such as death.

Further, with the addition of incorrect ingredients in medicine, adverse reactions can also occur because of the negative interaction between other medications in use and unknown ingredients. Nursing for Women's Health highlights, "The addition of harmful or incorrect ingredients to a medication can also cause significant health problems. Individuals may experience adverse reactions because of the ingestion of unsuspected ingredients or experience a negative interaction between these ingredients and other prescribed medications (Blackstone et al., 2014). Counterfeit medications may have been contaminated with substances such as heavy metals, reagents, and catalytic agents that are not appropriate for human consumption (Johnston & Holt, 2014). Additionally, counterfeit medications can enter the regulated supply chain and potentially be distributed in licensed pharmacies and hospitals, especially in developing countries (Blackstone et al., 2014). When counterfeit medications are discovered in hospitals and pharmacies where there is a regulated supply chain, concerns are raised among patients, which could lead them to doubt their health care providers or the health care system as a whole (WHO, 2017b)." [19]

Economic Effects of Counterfeit Medicine

With the rise of internet pharm, counterfeit drugs in the black market have increasingly affected economic intake in developed and developing countries alike and have posed significant problems to consumers. By analyzing black market influence of medicine in the United States, online pharmacy profits have dominated the revenue and economic power of the overall medical market within the developed economic structure of the country. The US National Library of Medicine from the National Institutes of Health emphasizes, "according to a 2009 report, online pharmacy sales were an estimated $11 billion that year, up from an estimated $4 billion in 2007.23 Early on, counterfeit drugs involved primarily so-called lifestyle drugs, especially sildenafil (Viagra), but the market has

[17] Fantasia, Heidi Collins, and Katherine M. Vooys. "Public Health Implications of Counterfeit Medications." *Nursing for Women's Health*, Elsevier, 6 June 2018, www.sciencedirect.com/science/article/abs/pii/S1751485118300990?casa_token=MDLdCtmeeW8AAAAA%3AUyKDrs4z9E73-ZB1LU5tmpzocDmVGyfESokeIKPj6EFWZ52QF3IuoXsegiysNBH_VmjUtTs.

[18] Fantasia, Heidi Collins, and Katherine M. Vooys. "Public Health Implications of Counterfeit Medications." *Nursing for Women's Health*, Elsevier, 6 June 2018, www.sciencedirect.com/science/article/abs/pii/S1751485118300990?casa_token=MDLdCtmeeW8AAAAA%3AUyKDrs4z9E73-ZB1LU5tmpzocDmVGyfESokeIKPj6EFWZ52QF3IuoXsegiysNBH_VmjUtTs.

[19] Fantasia, Heidi Collins, and Katherine M. Vooys. "Public Health Implications of Counterfeit Medications." *Nursing for Women's Health*, Elsevier, 6 June 2018, www.sciencedirect.com/science/article/abs/pii/S1751485118300990?casa_token=MDLdCtmeeW8AAAAA%3AUyKDrs4z9E73-ZB1LU5tmpzocDmVGyfESokeIKPj6EFWZ52QF3IuoXsegiysNBH_VmjUtTs.

expanded to include all types of therapeutic medicines, including insulin, cancer medications, and cardiovascular drugs. Although counterfeit drugs sometimes end up in the pharmaceutical supply chain, the primary source of counterfeit drugs is online pharmacies. The National Association of Boards of Pharmacy found that 97% of the Internet pharmacies it examined were not compliant with either federal or state laws, or with industry standards." [20] Over time, consumer interaction with online pharmacies that are not FDA approved have become increasingly common, with nearly 1 in 4 internet users buying from internet pharmacies, disrupting economic trade and losing mutually beneficial outcomes of intellectual property and innovation in medicine in the international marketplace and sphere.

Security Risks of Counterfeit Medicine

Some of the most prominent internet pharmacies have been predominantly linked to international terrorist organizations and groups as well as domestic security risks, posing a significant security threat to the international arena and developing technology spheres. According to the US National Library of Medicine from the National Institutes of Health, "some of these Internet sites are linked to terrorist groups, such as Hezbollah and Al Qaeda, and others are linked to organized crime—posing a threat to national and international security. In an attempt by these sites to make even more profit, consumers may face other consequences of an online drug purchase, including credit card fraud, identity theft, and computer viruses." [21] Because of the rise of new innovation and technological advancements, Because of these potential threats, black market medicine has become increasingly common in healthcare spheres, infiltrating computerized systems of medications, hacking important computerized software for healthcare databases, and exposing personal, medical information to domestic and international terrorist organizations and groups.

Current Situation and Committee Structure

The current situation of the black market's influence on medicine has been an increasingly prevalent issue among the international community. The influence of the illicit trading of goods and services within the healthcare industry is concerning, for it demonstrates that, in many cases, the "traditional" system of "healthcare is failing people", especially as many of these individuals are unable to afford the goods and services that the healthcare industry provides. [22] The focus of this committee would be to discuss the different variables that comprise the issues of black-market influence of medicine, including the impact on the health and welfare of individuals, the economic impact of such trade, and the consequences of the security of international markets and industries in this regard. The objective of this committee would be to find proper solutions that address the economic, social, medicinal and security repercussions present in developing and developed nations, and to originate innovative solutions that provide for a quality healthcare system to individuals abroad.

Questions Resolutions Must Consider

1. Why has there been an increase in the presence of counterfeit drugs in the international market?
2. What factors may push certain individuals in respective nations to turn to the black market to assess their health needs?
3. How do certain countries' healthcare systems, cultural ideologies, and social beliefs promote or repress black market activity?
4. How can counterfeit medicine pose significant health, economic and security risks to individuals and nations abroad?
5. How and why does the political, social, and economic organization of a country affect the quality of life and health within

[20] Blackstone, Erwin A., et al. "The Health and Economic Effects of Counterfeit Drugs." *American Health & Drug Benefits*, Engage Healthcare Communications, LLC, June 2014, www.ncbi.nlm.nih.gov/pmc/articles/PMC4105729/.

[21] Blackstone, Erwin A., et al. "The Health and Economic Effects of Counterfeit Drugs." *American Health & Drug Benefits*, Engage Healthcare Communications, LLC, June 2014, www.ncbi.nlm.nih.gov/pmc/articles/PMC4105729/.

[22] Europe PMC. "Hidden Health Crisis: Why People Turn to the Black Market for Medicine." *Europe PMC*, 10 Dec. 2019, europepmc.org/article/PMC/PMC4105729.

developed and developing healthcare spheres?

6. How do internet pharmacies pose a significant problem to the quality and access thereof of medicine in the international community?
7. How have the advancement of technology and innovation spurred the development of black-market influence in medicine in the international sphere?
8. What legal and ethical concerns may arise from the black-market influence of medicine in everyday life?

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