• Study Guide •

WORLD HEALTH ORGANIZATION

CCBMUN XIII

Do more than just watch!

· CCB ·

Colegio Colombo Británico

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1. Welcome letter.

"In a world challenged by multiple crises at the same time, global agencies working better together in supporting countries to turn around the impact on health and human capital is of paramount importance."

Dr Mamta Murthi, Vice President, Human Development, World Bank.

Dear delegates, the world is currently facing a situation of complex and constant-changing geopolitics. While many claim the world to be at peace, some others live in conflict or in extreme poverty, among all other kinds of situations that represent continuous violations of their human rights, especially the ones related to health.

Health, as one of the basic and fundamental rights, must be a priority for the International Community; the main objective of this commission is that all nations may reach the highest attainable standard of health, defined in its Constitution as a state of complete physical, mental and social well-being, and not merely the absence of a disease.

Even though the United Nations have been working for universal health compliance and protection, new problems and difficulties constantly emerge in the world, and right now, after a period of many changes, such as the COVID-19 pandemic, many of these efforts remain ineffective.

Due to the seriousness of the situation mentioned above, we Andrea and Isabella welcome you to the World Health Organization. We expect you to be fully prepared and perform satisfactorily on the seeking of progress in the implementation of equalitarian health, wellness, and the recognition of all the members who are part of it: the whole world.

Also, we wish that you all have a pleasant experience during CCBMUN XIII. Feel free to contact us for any inquiries you may have, we will be here for you at every moment.

Sincerely,

Andrea Uribe Marchena	Isabella Tilano
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2. Introduction to the Committee

The World Health Organization (WHO), which is committed to promote the health of all people and inspired by science, directs and supports international initiatives to ensure that everyone has an equal opportunity to live a healthy life. It links nations, partners, and people, in order to advance health, maintain global security, and help the most vulnerable. It has 194 Member States. (*About WHO*, n.d.)

The WHO coordinates the global response to major disease outbreaks. It played a prominent role in the 2014 Ebola outbreak, which it designated as a global emergency. Similarly to that, it coordinated the response to the Zika outbreak in 2015–16. It deemed the covid-19 coronavirus outbreak a pandemic in 2020 and urged governments to take drastic action to stop the disease's spread. The scope and range of action of the World Health Organization will be described in the following paragraphs.

2.1 Historical Background

During the San Francisco Conference in April 1945, representatives from Brazil and China suggested the creation of an international health organization and the convening of a conference to draft its constitution. (*History of WHO - History of WHO*, n.d.)

In Paris, from March 18th to April 5th, 1946, a Technical Preparatory Committee[1] drafted proposals for the Constitution that were presented to the International Health Conference in New York City, from 19 June to 22 July 1946. These suggestions served as the foundation for the Conference's creation and adoption of the World Health Organization's Constitution, which was ratified on July 22 by representatives of 51 UN Members and 10 other countries. (*History of WHO - History of WHO*, n.d.)

WHO should be a specialized agency of the UN, according to the preamble and Article 69 of the organization's constitution[2]. It entered into force on April 7, 1948, when it

[1] To check the official records of the World Health Organization: Minutes of the Technical Preparatory Committee for the International Health Conference; see https://apps.who.int/iris/bitstream/handle/10665/85572/Official_record1_eng.pdf?sequence=1&isAllowed=y

[2] For more information about the Constitution of the World Health Organization, it preamble, content and articles, see: https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1

was ratified by 26 members of the United Nations; we commemorate this day every year as World Health Day.

On June 24, 1948, the first Health Assembly[3] convened in Geneva, with participation from 53 of the 55 Member States. It was decided that WHO would take over as soon as the Interim Commission ceased to exist at midnight on August 31st, 1948.

WHO's Agenda for Progress

The WHO's five-year strategy, 2019-2023, is outlined in the Thirteenth General Programme of Work (GPW 13). In order to have measurable effects on people's health at the national level, it focuses on triple billion targets.

- "One billion more people are benefiting from universal health coverage.
- One billion more people are better protected from health emergencies.
- One billion more people are enjoying better health and well-being." (World Health Organization, n.d).

Key Areas of Work

At the WHO's headquarters, six important programmatic divisions coordinate efforts to achieve the Triple Billion targets[4].

- *Universal health coverage:* human rights related to health are secured by universal access to healthcare.

- *Health Emergencies Programme:* crucial in helping nations respond to and recover from health threats. join forces to combat the most urgent health crises, such as pandemics, natural disasters, humanitarian crises, and disease outbreaks.

[3] For more information see: https://apps.who.int/iris/bitstream/handle/10665/85592/Official_record13_eng.pdf?sequence=1&isAllowed=y
[4] Explained above, related to the WHO's agenda for progress. If you want more information about each triple billion targets, see: https://www.who.int/our-work

- *Access to Medicines and Health Products:* to protect people's health, it's essential to provide them with quality, safe, and effective medical products.

- *Antimicrobial Resistance:* develop comprehensive policies and strategies that prevent, reduce, and mitigate drug-resistant infections as well as the effects of antimicrobial resistance on the entire world.

- *Science Division:* In order to anticipate global health needs, validate public health recommendations, and transform innovation into workable solutions that everyone can rely on to improve their lives, WHO makes use of science.

- *Data, Analytics and Delivery for Impact:* publish authoritative reports on global health data trends and analysis.

2.2 Organization and Functions.

In terms of WHO's organization, it consists of the Secretariat, Member States, and the World Health Assembly.

- Secretariat: when we talk about the secretariat, we refer to the experts, staff, and field workers at the Geneva headquarters, the 6 Regional Offices, and other stations located across more than 150 nations.

- Member States: every Member State is assisted by WHO in achieving the highest level of health for all people. The international staff offers guidance on public health issues to ministries of health and other sectors, as well as assistance with the development, implementation, and evaluation of health programs.[5]

- World Health Assembly: is the highest governing body of WHO. Delegations from all Member States participate, and it focuses on a particular health agenda created by the

[5] For more information about each country, see: https://www.who.int/countries.

Executive Board[6], to set priorities and plot a course for advancements in global health. The assembly takes place annually in Geneva, Switzerland.[7]

WHO works internationally to advance health, ensure global security, and assist those who are vulnerable. These are the functions that it executes:

- "For universal health coverage:
  - Focus on primary health care to improve access to quality essential services.
  - Work towards sustainable financing and financial protection.
  - Improve access to essential medicines and health products.
  - Train the health workforce and advise on labor policies.
  - Support people's participation in national health policies.
  - Improve monitoring, data and information.

- For health emergencies:
  - Prepare for emergencies by identifying, mitigating and managing risks.
  - Prevent emergencies and support development of tools necessary during outbreaks.
  - Detecting and responding to acute health emergencies.
  - Support delivery of essential health services in fragile settings.

- For health and well-being:
  - Address social determinants.
  - Promote intersectoral approaches for health.
  - Prioritize health in all policies and healthy settings.

- Approaches WHO addresses with its work:
  - Human capital across the life-course.

[6] The World Health Assembly's agenda and the resolutions that the Health Assembly will be debating are decided upon by the Executive Board. The group is made up by 34 technically qualified members, who are elected to three-year terms.

[7] For more information about the documentation of WHO for Executive Board sessions and Health Assemblies, see: https://apps.who.int/gb/index.html.

- Noncommunicable diseases prevention.
- Mental health promotion.
- Climate change in small island developing states.
- Antimicrobial resistance.
- Elimination and eradication of high-impact communicable diseases."
  (World Health Organization, n.d)

2.3 Tools

The following is a list of tools and toolkits developed by WHO[8]:

- "AccessMod: geographic access to health care.
- Advancing data collection on Assistive Technology.
- AIDS Free.
- Air Quality Standards.
- ATC-DDD.
- Child growth standards.
- Core questions on household energy use.
- COVID-19 Clinical Care Pathway.
- COVID-19 impact on nutrition analytical framework.
- COVID-19 vaccine introduction.
- e-Library of Evidence for Nutrition Actions.
- Em Care.
- Essential Newborn Care Training course.
- FluMart.
- FluNet.
- Global Clinical Platform.
- Growth reference data for 5-19 years.
- Health Equity Assessment.
- Health impact assessment (HIA) tools and methods.
- HIV testing algorithm.
- Household Multiple Emission Sources (HOMES) model.
- Influenza vaccination toolkit.

[8] To receive more information about each tool, see: https://www.who.int/tools

- Integrating health in urban and territorial planning: the directory.
- MEL Manual.
- Monitoring and evaluating pharmaceutical situations in countries.
- Occupational burden of disease application.
- Occupational hazards in the health sector.
- OneHealth.
- Refugee and Migrant Health.
- Target Product profile database.
- WHOQOL: Measuring Quality of Life.
- WHO Zika App.
- Your life, your health - Tips and information for health and well-being." (World Health Organization, n.d)

2.4 Ground Documents

- Constitution of the World Health Organization.
- Rights and Obligations of Associate Members and other Territories.
- Convention on the Privileges and Immunities of the Specialized.
- Agreements with other Intergovernmental Organizations.
- Framework of Engagement with Non-State Actors.
- Financial Regulations of the World Health Organization.
- Regulations for Expert Advisory Panels and Committees.
- Regulations for Study and Scientific Groups, Collaborating Institutions and Other Mechanisms of Collaboration. [9]

3. Topic A: Creation of International Programmes to Guarantee Healthcare to Refugees.

3.1 Introduction

To start analyzing the current issues that are affecting one of the most valuable rights, the access to healthcare for everyone, especially for refugees, it's important to have a clear

[9] For more information about these documents, see: https://apps.who.int/gb/bd/

perspective of what is needed to guarantee such access. Additionally, it is crucial to bear in mind the particular precarious situation faced by refugees to create appropriate international programmes.

The capacity to receive healthcare services such as prevention, diagnosis, treatment; and management of diseases, illnesses, disorders, and other health-related situations is referred to as healthcare access. It must be both economical and easy to implement in order to be accessible. (University of Missouri, n.d.)

Thousands of people lack access to quality healthcare. Despite the programs that have been applied in several countries, such as the Centers for Medicare and Medicaid Services (CMS) in the United States of America, the efforts are not enough, and this is widespread in the nations of the Global South as well as the Global North. Governments, institutions, and healthcare workers must make challenging choices about delivering adequate healthcare to people, especially to the one that is needed the most. Healthcare accessibility is a moral and public policy concern that all nations must take into consideration.

The challenge of poverty, the numerous impediments to healthcare access, and the issue of healthcare resource distribution are three major topics that preclude healthcare access. These themes spark debates on the role and alleviation of poverty, how to overcome access barriers, and how to allocate scarce resources properly. (University of Missouri, n.d.)

- Poverty: is defined as a lack of the necessary resources for an adequate standard of living, such as shelter, food, clothing, schooling, and healthcare. We normally gain such goods by purchasing them, so poverty is frequently viewed as an issue of income and wealth. Relative poverty will always exist as long as no one has the same level of wealth or income, yet it is not always a problem that needs to be solved. In our case, taking into consideration the refugee status, they will not have the same guarantees as the own people of a country. The situation in which refugees arrive in a country is unfortunate, and it will be shown later that, although there are treaties and conventions that seek a certain equality of conditions for refugees in the country they arrive in, this is almost never fulfilled, or other priorities above. (University of Missouri, n.d.)

These are the most common causes of poverty, that lead to preventing access to health care:

- Lacking natural resources, employment skills, and education.
- Age, sexual orientation, race, and ethnicity discrimination in hiring.
- Roads, communications, effective government, healthcare facilities, and educational facilities are all lacking.
- Warfare.
- Natural disasters (hurricanes, earthquakes, soil erosion, floods, and droughts).
- Religious beliefs about natural disasters being divine punishment, fatalism, and the idea that the political and economic system is "God's will" all work against alleviation efforts.
- Water pollution in particular.

The vast majority of thinkers consider that access to healthcare and poverty are slightly inversely connected. Healthcare is generally more difficult to access in developing nations. Additionally, within a nation, wealthy people typically have better access to healthcare than others.

- Barriers to Access: another way to approach the issue of healthcare access is to think of certain things as "barriers", such as:

  - Insufficient organ donors exist for transplant.
  - Lack of primary care doctors.
  - Insufficient medical schools.
  - Rural poverty and urban blight limit the appeal of those areas for medical practices.
  - Poor patients are unable to get accessible and economical transportation to travel to distant medical offices or hospitals.
  - Patients are unable to access cheap childcare.
  - Limited hours, protracted wait times, and insufficient after-hours treatment.

- Insurance is not affordable for some populations.
- Limited access to computers and the Internet.
- Foreign nationals living illegally are in a worse legal situation.
- The local facilities do not speak the patient's native language.
- Healthcare facilities and professionals are lacking in the country.
- Tropical nations with inadequate healthcare resources, climate variables lead to illness causes that overwhelm those resources.

The healthcare system of a nation consists of healthcare professionals, patients, payers, research studies, programs, institutions, organizations, affiliated companies, laws, rules, and policies. Some nations have a system that is largely private and offers healthcare to those who can afford it or pay for insurance. Some nations have a "Universal Healthcare System”[10]. There are several possible outcomes for this. In a "National Health System"[11], like the one in the United Kingdom of Great Britain and Northern Ireland, the government owns and runs many healthcare institutions and professionals, though there are also private providers. The majority of healthcare professionals work for private employers under a "National Health Insurance System"[12], like in Canada, but they are compensated by the state under a "single payer" system. Government funds are used to pay for healthcare.

Healthcare professionals work for private employers under a "Socialised Health Insurance System”[13], like in Germany, although the government mandates employee contributions (payroll taxes) that finance private insurance (sickness funds). In comparison to most other industrialized nations, the United States has a hybrid private/public system with more privatization. Finance for healthcare is provided by various taxes. However, the fundamental tenet of all such systems is the provision of healthcare to all. (University of Missouri, n.d.)

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[10] In a government-run healthcare system, all healthcare services are provided and all facilities and staff are owned, operated, and paid for by the government.

[11] It alludes to the publicly subsidized medical and healthcare services that UK residents may get without having to pay the full cost of the service. Visiting a doctor or a nurse at a medical office is one of these services.

[12] A mandatory public insurance scheme that covers the entire population.

[13] Contributions from employees, self-employed individuals, businesses, and governments are mandatory aggregated into a single or many funds.

The expense of new technology, better and more thorough patient care and illness treatment, sedentary habits and inadequate nutrition, and elderly people are all factors driving up healthcare costs in developed nations.

Healthcare is typically not an endless resource. There must be concessions and trade-offs. Some people either need to obtain appropriate healthcare, or healthcare costs are high, or certain healthcare services have lengthy wait times, or healthcare personnel are paid comparatively severely, or some combination of these things happens. (University of Missouri, n.d.)

According to the World Health Organization (WHO), more than one billion people are on the move globally, accounting for roughly one-eighth of the world's population. Furthermore, the number of displaced individuals is likely to rise as a result of poverty, insecurity, a lack of access to essential services, violence, environmental degradation and disasters, and other issues indicated above. (n.d). Social, political, and economic exclusion can lead to poverty, homelessness, and exploitation, all of which raise the risk of noncommunicable illnesses, especially if the conditions of arrival in a country are not adequate. (World Health Organization, 2022)

> *"According to Article 23 of the 1951 Refugee Convention[14]refugees have the same right to public assistance as nationals of their host country, including health care. Asylum seekers are included under this privilege." (UNICEF Advocacy Brief Health, n.d)*

Taking this statement as a baseline, the problem that we are going to discuss is not only the access to good health and the guarantees that a state can offer to people regardless of their origin or the situation in which they find themselves; it is also important to consider that if there is already a convention that protects the rights of refugees, why is there no full coverage for their treatment and many countries do not commit to them?

[14] See the historical background, where the convection and the status of refugees are explained.

3.2 Historical Background

There is no documented history of how refugees have been directly impacted by a lack of access to health care, but there have long been numerous variables affecting them.

The 1951 Refugee Convention was the most comprehensive codification of the international rights of refugees, defining a new category of protected persons and specifying what it means to respect refugees' human rights, bringing them to the attention of the international community.Refugees' physical and mental health needs are affected by their experiences in their home country, their migratory path, their host nation's entrance and integration regulations, and living and working situations. These experiences can make them more susceptible to chronic and infectious diseases. (World Health Organization, 2022)

Refugees are among the world's most vulnerable people. The 1951 Refugee Convention, as amended by the 1967 Protocol, provides some protection, but it has not been fulfilled as expected. The 1951 Convention's central concept is non-refoulement, which states that a refugee shall not be returned to a country where they suffer substantial dangers to their life or freedom.

The statement specifies the fundamental minimum requirements for the treatment of refugees, such as the right to housing, job, health, and education while displaced in order to live a dignified and independent life. It also defines a refugee's obligations to host countries and specifies specific kinds of people who do not qualify for refugee status, such as war criminals. (UNHCR, n.d.)

3.2.1 History of the 1951 Refugee Convention

Following the First World War (1914-1918), millions of people abandoned their homes in quest of safety. Governments responded by drafting a series of international treaties to provide travel credentials for these people, who were effectively the twentieth century's first recognized refugees. Their numbers grew considerably during the course of World War II (1939-1945), when millions of people were forcibly relocated. As a result, the International Community has progressively compiled a collection of principles, regulations, and agreements aimed at defending basic human rights and treating persons compelled to leave conflict and persecution. (UNHCR, n.d.)

The 1951 Refugee Convention, which consolidated and expanded on earlier international instruments relating to refugees, and which continues to provide the most thorough codification of refugee rights at the international level, was the conclusion of the process, which started under the command of the League of Nations in 1921. (UNHCR, n.d.)

A diplomatic meeting in Geneva in July 1951 resulted in the adoption of the Convention Relating to the Status of Refugees. Since then, there has only been one modification, the 1967 Protocol.[15]

The declaration bears the phrase "events occurring before 1 January 1951," which is generally taken to imply "events occurring in Europe" previous to that date. Initially, it was literally limited to defending European refugees in the wake of World War II. The 1967 Protocol, ratified on October 4, 1967, eliminates these geographical and time-based restrictions, allowing the Convention to apply unconditionally and protect all those escaping violence and persecution. All countries that have ratified the Protocol agree to implement the Convention's requirements as well. There are currently 149 states that have signed on to either the Convention or the Protocol. At the moment, 146 countries have ratified the 1951 Convention[16] and 147 have ratified the 1967 Protocol[17]. (Andrew & Renata Kaldor Centre for International Refugee Law, 2023)

3.2.2 Refugee's Definition

According to Article 1 of the 1951 Convention, a refugee is someone who is "outside the country of their nationality due to legitimate fears of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, and is

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[15] To have access to the 1951 Convention and 1967 Protocol, see: https://www.unhcr.org/media/convention-and-protocol-relating-status-refugees

[16] For more information about the countries that have ratified the 1951 Refugee Convention, see: https://treaties.un.org/pages/ViewDetailsII.aspx?src=TREATY&mtdsg_no=V-2&chapter=5&Temp=mtdsg2&clang=_en

[17] For more information about the countries that have ratified the 1967 Protocol, see: https://treaties.un.org/pages/ViewDetails.aspx?src=IND&mtdsg_no=V-5&chapter=5

unable or, due to such fear, is unwilling to avail themselves of the protection of that country; or who, not having a nationality and being outside the country of their former."(Refugee Convention, Article. 1, 1951)

Regional refugee instruments add to and expand upon the 1951 Refugee Convention's definition by mentioning a number of objectives or reasons why refugees would need to leave their home countries. For instance, the OAU (Organization of African Unity) Refugee Convention from 1969 specifies that external aggression, occupation, foreign domination, or events seriously disturbing public order are included in the criteria (Article 1 (2)). Generalized violence, foreign aggression, internal conflicts, massive violations of human rights, and other events that substantially disturb public order. (UNHCR, n.d.)

People may experience such severe violations of their human rights that they are forced to flee their homes, their families, and their communities in order to find safety in another country. This is often the case for political reasons, based on discrimination, or due to conflict, violence, and other situations seriously disturbing public order. Refugees are safeguarded by the international community because, by definition, their own governments are not responsible for protecting them. The 1951 Convention makes nations safeguard refugees on their soil and treat them in accordance with accepted international norms.

The socioeconomic determinants of health, including employment, income, education, and housing, have a significant impact on the health of migrants and refugees.

As a varied community, refugees may have different health needs from those of the host populations. They frequently originate from areas that have been impacted by armed conflict, disasters, environmental degradation, or economic hardship. They travel for extended periods of time and exert themselves physically, which increases their vulnerability to communicable diseases, including measles, and water- and food-borne illnesses. They also have insufficient access to food, water, sanitation, and other essential services. Due to their migratory experience, stringent entry and integration regulations, and isolation, they may also be at risk for unintentional accidents, hypothermia, burns, unintended pregnancy and delivery-related difficulties, and numerous noncommunicable diseases.

Additionally, because they were untreated during the travel, individuals can arrive in the destination nation with non-communicable diseases that are not under good control. For female refugees and migrants, maternity care is typically their first point of contact with the health system.

Because of their traumatic or stressful experiences, refugees may also be more susceptible to mental health problems. Numerous of them report experiencing anxiety, sadness, hopelessness, trouble sleeping, exhaustion, irritability, anger, or aches and pains, though most people find that these symptoms of distress pass with time. They may be more vulnerable to developing conditions like post-traumatic stress disorder (PTSD) and depression than the host populations. (World Health Organization, 2022)

3.2.3 Differences Between Migrants, Asylum Seekers and Refugees.

The terms “refugee”, “asylum seeker” and “migrant” are used to describe people who are moving, they left their countries and crossed the borders; however, they are used in different ways, and each one has various specifications.

A refugee, as established in the 1951 Convention, is someone who is outside its own country searching for new opportunities due to its legitimate fears of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinions, etc. (UNHCR, n.d.)

An asylum seeker is someone that basically has the same conditions and reasons of a refugee for leaving their country; the difference lies in the international recognition they don’t have, but they are waiting for an asylum claim.

There is no universally recognized legal definition of a migrant. Migrants, like most agencies and organizations, are individuals who live outside their nation of origin, but are not asylum seekers or refugees. They leave their country to work, study, or join relatives, for example. Others believe they must flee due to poverty, political upheaval, gang violence, natural disasters, or other terrible circumstances. (McNew, 2023)

3.2.4 Refugee Status Determination

The RSD (Refugee Status Determination) is the legal or administrative procedure through which countries or the UNHCR evaluate whether a person requesting international protection is a refugee under international, regional, or national law. RSD is frequently a critical process in assisting refugees in realizing their rights under international law. (UNHCR, n.d.)[18]

RSD is primarily the duty of the states, but when a state is not a signatory to the 1951 Refugee Convention, or does not have a fair and effective national asylum system in place, UNHCR may conduct RSD in accordance with its mandate.

UNHCR collaborates closely with governments to help them take on more responsibility for RSD and to enhance its systems. It encourages nations to create national systems that are just, effective, adaptive, honest, and that result in high-quality decisions. The UNHCR will set up an Asylum Capacity Support Group to help governments develop or improve their national asylum systems. This group will work within the larger framework of the Global Compact on Refugees, which was endorsed by the UN General Assembly on December 17th of 2018[19].

3.3 Current Situation

"Health does not begin and end at country borders, but health services and social protections do: public health must include refugees and migrants"
World Health Organization.

As indicated in our commitment to universal health coverage, WHO believes that everyone, including refugees, should have the right to health and access to people-centered, high-quality health care without financial barriers. National and municipal health policies, finance, planning, implementation, monitoring, and evaluation should include the requirements of refugees and migrants. In order to respond quickly and effectively to emergencies, health care may need to be administered in a parallel structure to the national

[18] Here you will find a map of UNHCR Mandate RSD as sole Refugee Status Determination Procedure, as of August 2021: https://www.unhcr.org/sites/default/files/legacy-pdf/611a6d5a4.pdf

[19] For further information about the Resolution adopted by the General Assembly on 17 December 2018, see: informationhttps://www.unhcr.org/media/resolution-adopted-general-assembly-17-december-2018

health system at times, but in the long run, refugee's health should be integrated into current systems.

Throughout the years, the world has been looking for a way to provide access to health care to everyone, but despite the attempts, due to several factors mentioned above, it has not worked. The most recent one is to talk about the Sustainable Development Goals, especially number 3, which states that countries need to ensure healthy lives and promote well-being for all at all ages.

Persecution, conflict, violence, human rights violations, and events that have gravely disrupted public order have driven 108.4 million people worldwide to depart their homes. Among them are 35.3 million refugees, who are considered the most vulnerable and neglected groups in many nations. It is not only the fact of taking into consideration the reasons why a person has the need to leave their country, but also the conditions in the neighboring countries, which are generally the first options for refuge.

3.3.1 Europe[20]

By the end of 2022, there were 21.8 million forcibly displaced and stateless persons in Europe, comprising about 12.4 million refugees, 1.3 million asylum seekers, 7.2 million internally displaced people (IDPs), and 474,000 stateless people. (UNHCR, 2022)

All EU and EEA (European Economic Area) nations consider the right to health care to be a fundamental social right for children, including asylum seekers and refugee children. However, in times of crisis, the vast majority of these countries have been shown to have healthcare policies that limit entitlements to healthcare for the most vulnerable children and fail to uphold the children's rights to which they claim devotion. (Ostergaard et al., 2017).

Forcing governments to uphold their duties under the United Nations Convention on the Rights of the Child and clearly grant all children the same rights to health care can be a crucial strategy for promoting improved access to care for children in Europe who are refugees or seeking asylum.

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[20] To have more information about the refugees' health status and healthcare in Europe, see: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-020-08749-8

The UNHCR's efforts in Ukraine and the surrounding nations that host refugees have been greatly expanded as a result of the emergency in Ukraine. 4.3 million internally displaced people (IDPs) in Ukraine received protection and assistance from UNHCR, including cash aid for over 1 million people. Nearly 1.5 million individuals benefited from UNHCR's winterization initiatives, which included cash top-ups, winterized non-food items, improved reception facilities, and home repairs. Over 650 humanitarian convoys, including inter-agency convoys, prioritized providing humanitarian aid in frontline and newly accessible locations. UNHCR provided 500,000 refugees in refugee-hosting nations with financial assistance and 500,000 with protection services.

In order to be a part of national systems and local communities, nearly 5 million Ukrainian refugees registered under the Temporary Protection Directive of the European Union and comparable national programs. Through the Regional Refugee Response Plan for Ukraine, UNHCR coordinated 142 partners in seven nations in support of national responses. The aid provided by UNHCR to refugees includes protection counseling, as well as assistance with accessing healthcare, education, special needs assistance, housing, and employment opportunities. 39 "Blue Dot hubs" created by UNHCR, UNICEF, and other partners to facilitate access to information, services, and referrals for people with unique needs have reached about 186,000 people. Additionally, 1.7 million people were exposed to important messages about safety through the "Stay Safe" campaign. (UNHCR, 2022)

The arrival of 159,400 refugees and migrants via the Mediterranean and north-west African maritime routes increased by 29%, putting further strain on national reception facilities. Arrivals in Greece more than doubled to 18,800, grew 37% to 4,000 in Cyprus, and increased 55% to 104,500 in Italy. Over 400 refugees and migrants arrived in Malta, representing a 48% fall, while arrivals via the western Mediterranean and north-west African maritime routes fell by 36% to 31,800. (UNHCR, 2022)

The UNHCR maintains its long-standing support for the "Pact on Migration and Asylum" presented by the European Commission, an opportunity to establish a legal framework for swift and equitable asylum proceedings as well as mechanisms for state cooperation and responsibility-sharing. Additionally, UNHCR worked with EU institutions and Member States to find creative, legal solutions to handle the complicated mixed

migration flows into Europe. However, UNHCR cautioned against ideas that can be seen as weakening or externalizing asylum commitments, standards, and procedures. (UNHCR, 2022)

3.3.2 Asia and the Pacific[21]

By the end of 2022, Asia and the Pacific had hosted approximately a total of 6.8 million refugees, 5.0 million internally displaced people (IDPs), and 1.2 million stateless people. UNHCR increased its efforts to safeguard protection and asylum space, to "stay and deliver" protection, support, and critical services, to secure solutions routes, and to establish a diverse range of strategic and innovative partnerships - even in the most complicated operational situations. (UN Refugee Agency, 2022)

In Turkey, UNHCR's advocacy and collaboration with the Presidency of Migration Management (PMM) increased Afghans', Iraqis', Syrians', and Ukrainians' access to protection processes and services. The UNHCR assisted PMM in updating 3 million people's data and assessing the protection requirements of 156,000. Approximately 10,000 refugees received cash support, 46,000 received in-kind help, and 77,000 received specialized services to meet unique needs. UNHCR submitted 20,400 refugees for resettlement consideration while assisting 10,100 persons to leave for other countries throughout the world, a 37% increase over 2021. (UNHCR, 2022)

Although the violence in Afghanistan has largely subsided since the Taliban's takeover in August 2021, and 236,200 IDPs have chosen to return in 2022, the humanitarian crisis continues to worsen. Fundamental human rights violations, such as girls' access to secondary and higher education and women's access to employment, hampered recovery efforts and threatened to reverse advances. Since 2021, 1.6 million Afghans have migrated to the Islamic Republics of Iran and Pakistan, which have hosted Afghan refugees over the past four decades. Climate catastrophes and natural disasters exacerbated life's precariousness, as shown in Pakistan, when enormous floods displaced 800,000 people. (UNHCR, 2022)

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[21] For further information about Asia and the Pacific, see: https://reporting.unhcr.org/operational/regions/asia-and-pacific

In order to more effectively communicate international burdens and responsibilities, UNHCR advocated for expanded resettlement opportunities, promoted the regional support platform for the Solutions Strategy for Afghan Refugees, and adopted an area-based approach to address the immediate needs of displaced Afghans. It also strengthened access to education, livelihood opportunities, and health services in affected communities, which helped those communities become more resilient. 6.1 million Afghans received support from UNHCR, including 4.1 million through community-based initiatives, 1.5 million received financial aid, and 560,000 received in-kind and other forms of assistance. UNHCR constructed or improved 23 schools in Afghanistan, distributed 11,200 emergency shelter kits, and offered 41,000 people psychosocial support to help women and girls in particular. Over 1 million Afghan and Iraqi refugees were reached by an integrated vaccination campaign in the Islamic Republic of Iran, which was backed by the UNHCR and the government. (UN Refugee Agency, 2022)

By the end of 2022, about 1.2 million people in Myanmar had been displaced by the political turmoil and conflict that followed the military coup in February 2021, adding to the 330,000 people who had already been relocated. When it was possible, UNHCR provided important protection services and necessities to communities that had been displaced due to violence and insecurity. It also advocated with the *de facto* authorities for the respect of human rights and humanitarian access. With the help of UNDP, UNHCR continues community-led projects that have already assisted 60,000 individuals in Rakhine state, reaching 426,000 people with shelter support or basic relief supplies. (UN Refugee Agency, 2022)

3.3.3 The Americas[22]

There are 239 Global Refugee Forum commitments from the Americas region, 33 of which were added at the 2021 High-Level Officials Meeting. Progress on 125 pledges, or 52% of the total, has been confirmed by UNHCR, with 21% of them having been met. (Global Focus UNHCR, 2022)

[22] To have more information about the situation in the Americas, see: https://reporting.unhcr.org/globalreport/americas

To increase access to rights and provide documentation, Brazil, Colombia, the Dominican Republic, Ecuador, and Peru have started a variety of regularization processes. More than 500,000 Venezuelan applicants received some kind of regular stay approval in 2021, and regularization might be advantageous for more than 3 million migrants and refugees. More than 1.8 million people from Colombia have applied for temporary protection status. Over 300,000 people who completed biometric registration have been approved and got their documents, totaling 1.2 million.

As part of the regional implementation of the Global Compact on Refugees and the MIRPS, UNHCR assisted Belize, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, and Panama in responding to the increased needs of people seeking international protection, improving access to asylum systems, regular stay arrangements, and documentation, as well as by including people in social protection schemes and providing shelter, cash assistance, or social security. (Global Focus UNHCR, 2022)

Under a relocation program organized in collaboration with national authorities such as the Mexican Commission for Refugee Assistance, Mexico connected approximately 18,000 refugees and asylum seekers with formal work prospects. The increased economic activity benefited local communities, while refugees employed by more than 260 businesses contributed $5 million in taxes. The UNHCR assisted with temporary housing, cultural orientation, vocational training, school enrollment, and job placement with the help of private sector foundations and in partnership with federal and municipal authorities.

The UNHCR continues to assist with the Bolivarian Republic of Venezuela's Humanitarian Response Plan implementation and served as the cluster leader for protection, as well as the cluster in charge of shelter, energy, and basic relief supplies. In 71 prioritized communities, particularly in border regions, 1.9 million people, including members of the host community, those who were moving or at risk of moving, and spontaneous returnees, received direct or indirect assistance in 2021. This assistance included access to community centers and temporary shelters, health services, and food assistance for the most vulnerable. Additionally, UNHCR offered technical support for managing and coordinating shelters, increased support for reception areas, temporary shelters, and public health facilities, and supported public health initiatives. (Global Focus UNHCR, 2022)

In Brazil and Mexico, over 68,000 people were relocated from regions where they had little prospect of economic integration to parts of the country where they were matched to available jobs. In Colombia, the UNHCR promoted increased access to the labor market and financial services for Venezuelans who will receive Temporary Protection Status. (UNHCR Global Focus, 2022)

3.3.4 Covid-19[23]

Health services have been interrupted by the COVID-19 pandemic, putting those who are already at risk in greater danger and making it more difficult for health systems to meet their requirements. For migrants and refugees, it has raised the danger of infection and mortality. People who are constantly moving may only have a few tools at their disposal to defend themselves, making it difficult for them to isolate themselves or maintain good hand hygiene. (MUN Refugee Challenge, 2021)

The pandemic has brought attention to existing gaps in the use of and access to health services. The adverse financial consequences of lockdown and travel restrictions have also been felt by refugees. It's possible that workers were disproportionately impacted by income loss and healthcare instability. As a result of decisions on their status being delayed or a reduction in employment, legal, and administrative services, they may have also experienced legal and social insecurity. The trauma of surviving war, violence, persecution, and discrimination has already caused them to struggle. The anxiety caused by the possibility of catching COVID-19 or losing their jobs, as well as the isolation and loneliness felt during lockdowns, have made mental health problems worse and needed additional treatment.

WHO launched the Health and Migration Programme (PHM) in 2020 to provide global leadership in health and migration issues within the context of WHO's own Global Action Plan: Promoting Refugee and Migrant Health 2019-23.[24]

[23] To have more information about the refugees and the impact of COVID-19, see: https://www.unhcr.org/media/refugees-and-impact-covid-19

[24] Here you could have more information about WHO’s action plan: https://www.who.int/publications/i/item/WHA72-2019-REC-1

3.4 Guiding Questions

1. How does the health system work in your delegation, and what guarantees does it provide to refugees?

2. Regarding your delegation's foreign policy, is it generally in favor of welcoming refugees and providing them with a good quality of life and access to healthcare? Or does it avoid the commitment, with the International Community, to accept them, regardless of their situation?

3. What factors does your delegation consider prevent all refugees from enjoying access to health care at all? What could you suggest to mitigate the problem?

4. How would your delegation justify the importance of health for all people, including refugees?, and despite the economic and political conditions it possesses, how would it generate programs that begin to provide healthcare access for them?

5. What is the condition of the health system in your delegation, and how do you think it could be improved? How much help would be needed from the International Community to make it stable and provide benefits to all those who belong or enter your country?

6. What organizations does your delegation cooperate with to seek a change, either in the health systems and resources they have or in the guarantees that refugees need?

7. How did the COVID-19 pandemic affect the health situation in your delegation, and what has been done to recover it? Before the pandemic, were the guarantees you offered to the refugees the same, or did you have to make certain adjustments due to the limitations presented by the covid 19 disease?

8. What would your delegation be able to contribute to those other delegations that are unstable and, because of their conditions of scarcity or conflict, are unable to directly support their populations, thus increasing the number of people seeking refuge elsewhere?

9. Does your delegation think that it is possible to reduce the number of refugees by mitigating the problems directly with the countries involved in the problems? If so, how would your delegation ensure better health conditions for those who already exist, if their number is being reduced?

3.5 Recommendations

It is important to understand the concept of refugees, the current situation in which they find themselves, and how they obtain their status. In order to create international programs, it is also necessary to understand the basic needs of a good health system; then analyze the health system of each delegation and determine what is lacking to provide access to refugees. Keep in mind that in each country the situation is different, and although there are conventions and treaties that seek to protect refugees, many countries do not comply with them. This is why you should look for ways in which you can effectively guarantee refugees the right to have good access to health care, which all people should enjoy.

Remember that you can contact us, Isabella and Andrea, in case you need anything or have any questions.

3.6 Useful Links

- UNHCR. (1951). The 1951 Refugee Convention. UNHCR. Retrieved August 25, 2023, from https://www.unhcr.org/about-unhcr/who-we-are/1951-refugee-convention
- UNHCR. (1951 - 1967). Convention and Protocol Relating to the Status of Refugees. UNHCR. Retrieved August 27, 2023, from https://www.unhcr.org/media/convention-and-protocol-relating-status-refugees
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- European Journal of Public Health. (2022). Health and health care for refugees and migrants. Oxford Academic. Retrieved 07 27, 2023, from https://academic.oup.com/eurpub/pages/health-care-for-refugees-and-migrants
- World Health Organization. (2018, April 4). . World Health Organization. Retrieved August 27, 2023, from https://www.who.int/publications/i/item/health-of-refugees-and-migrants---who-african-region-(2018)

3.7 Glossary

- **Barriers to healthcare access:** in order to address systemic inequity, healthcare systems must face and remove a number of obstacles that prevent patients from receiving high-quality, equitable care, including inadequate insurance coverage, a lack of healthcare workers, stigma and bias within the medical profession, obstacles related to transportation and employment, and patient language barriers.

- **Healthcare system:** includes all groups, individuals, and activities whose major goal is to advance, preserve, or restore health. This covers actions that influence the factors that affect health as well as more direct actions that enhance health. Because of this, a health system encompasses not just the pyramid of publicly owned facilities that provide personal health services, but also the organizations, individuals, and resources engaged in providing health care to people.

- **Refugee:** individuals who have fled their homes and crossed an international boundary in search of protection in another country.

- **Right to health:** everyone should have access to the health care they require, when and where they require it, without financial difficulty. No one should become ill and die simply because they are poor or lack access to necessary health care.

- **SDG # 3:** it states that ensuring healthy lives and encouraging well-being for all ages is critical to long-term development. The COVID-19 epidemic is still causing human pain.

4. Topic B: Evaluation of the Impact of Psychoactive Drugs in Medications, and its Repercussions on People's Health.

4.1 Introduction

Psychoactive medications are substances that modify brain function, resulting in emotion, thinking, perception, and/or behavioral changes. Psychoactive medications can be used for a variety of goals, including medicinal, ritualistic, and recreational ones. Cocaine, LSD, alcohol, tobacco, codeine, and morphine are all examples of psychoactive drugs, many of which are used to relieve pain, such as codeine or morphine, which are legally authorized pharmaceuticals.

Many psychoactive medications are either banned or prohibited from being produced, distributed, sold, or used for non-medical purposes outside of officially sanctioned channels. They have different degrees of availability restrictions based on their health concerns and therapeutic efficacy. Those drugs can be categorized according to a hierarchy of schedules at both the national and international levels. Some international drug conventions concerned with the control of the production and distribution of psychoactive drugs are:

- The 1961 Single Convention on Narcotic Drugs, amended by a 1972 Protocol.
- The 1971 Convention on Psychotropic Substances.
- The 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

4.1.1 Psychoactive Drug Classification

Psychoactives are classified into many classes based on their pharmacological effects.

- Stimulants: excite the brain and promote alertness and wakefulness, such as caffeine, nicotine, cocaine, and amphetamines like Adderall.
- Depressants: medications that relax the brain, lessen anxiety, and make you sleepy, such as heroin and opiates like codeine.
- Anxiolytics: have a calming effect and inhibit anxiety, like benzodiazepines such as diazepam, barbiturates, opioids, and antidepressant medications.
- Euphoriants: drugs that induce euphoria, or intense emotions of well-being and happiness, such as the club drug MDMA (ecstasy), amphetamines, ethanol, and opioids such as morphine.

- <u>Hallucinogens:</u> Drugs that might create hallucinations and other perceptual irregularities, they also cause subjective alterations in thoughts, emotions, and consciousness, such as LSD, ecstasy, ketamine and salvia.
- <u>Empathogens:</u> substances that cause feelings of empathy or sympathy for others, such as amphetamines and MDMA.

Psychoactive medicines generally work by altering brain chemistry, which can result in changes in a person's mood, thinking, perception, and/or behavior. Each medicine has a distinct effect on one or more neurotransmitters - or neurotransmitter receptors in the brain. In general, they function as either agonists or antagonists.

- Agonists: medications that boost the action of certain neurotransmitters. They may work by increasing neurotransmitter production, decreasing synaptic reuptake, or mimicking their activity by attaching to neurotransmitter receptors.
- Antagonists: medications that inhibit the activity of particular neurotransmitters. They may function by interfering with neurotransmitter synthesis, or by inhibiting neurotransmitter receptors so that neurotransmitters cannot connect to them.

General anesthesia, in which pain is inhibited and unconsciousness is produced, is one of the medical applications of psychoactive substances. The majority of them are used during surgical procedures and can be given in gaseous form. The medications such as halothane and ketamine are examples of general anesthetics. Other psychoactive substances are used to alleviate pain without impairing consciousness. They can be prescribed for acute pain from trauma, such as broken bones, or for chronic pain from arthritis, cancer, or fibromyalgia. Opioids, such as morphine and codeine, are the most commonly used pain relievers.

Psychoactive medications are also used to treat a variety of psychiatric diseases. Antidepressants, for example, such as sertraline, are used to treat depression, anxiety, and eating disorders. Anxiolytics, such as buspirone and diazepam, can also be used to treat anxiety disorders. Amphetamines and other stimulants are used to treat attention deficit disorder. To treat schizophrenia and bipolar disorder, antipsychotics such as clozapine and risperidone, as well as mood stabilizers such as lithium, are used.

The use of psychoactive drugs without medical supervision carries serious health hazards, and can lead to the development of drug use disorders. Untreated drug use problems increase morbidity and mortality risks for individuals, cause significant suffering, and impede personal, family, social, educational, occupational, or other critical areas of functioning. Drug use disorders have large societal costs due to lost productivity, premature death, increased health-care expenditures, and other costs linked with criminal justice, social welfare, and social implications. (World Health Organization, n.d.)

Psychoactive substances frequently generate subjective changes that the user might find delightful (euphoria) or beneficial (e.g., enhanced attentiveness). Since these changes are pleasurable and positively reinforcing, there is a risk of misuse, addiction, and dependence. Addiction is defined as the obsessive use of a drug despite the negative effects of such usage. Long-term usage of an addictive drug can result in drug dependence. Physical and/or psychological dependence can exist. It happens when a person stops using drugs and he/she experiences withdrawal symptoms. Physical dependency causes withdrawal symptoms such as tremors, discomfort, seizures, or sleeplessness. Psychological withdrawal symptoms, such as anxiety, despair, paranoia, or hallucinations, are caused by psychological dependence.

4.1.2 Opioid Overdose

Opioids refer to substances that can interact with opioid receptors in the brain, including substances derived from poppy seeds, as well as semi- and synthetic substances with comparable capabilities. Opioids are frequently used to reduce pain because of their analgesic and sedative properties. Euphoria is a common side effect of opioid use after ingestion, and is one of the main reasons they are used recreationally. Heroin, morphine, codeine, fentanyl, methadone, tramadol, and other drugs with a similar structure are examples of opioids, they are frequently used to alleviate pain. Their misuse, abuse, and use beyond prescribed medical purposes can result in opioid dependence and other health issues. (World Health Organization, 2021)

About 500.000 deaths worldwide are linked to drug usage. Overdoses account for more than 30% of these deaths, which have an opioid connection in excess of 70%. Approximately 115.000 individuals died from opioid overdoses in 2017, according to estimates from the WHO. Opioid overdoses that do not result in death are much more frequent than overdoses that do. The number of opioid overdoses has increased recently in a number of nations, in part because more people are using opioids to treat their chronic pain, and more extremely strong opioids are becoming available on the black market. (World Health Organization, 2021)

Opioid receptors are attached to and activated by opioids. These receptors are found in a number of regions of the brain, spinal cord, and other organs, particularly those that are involved in the pleasure and pain feelings. Opioids bind to the receptors and release a significant amount of dopamine throughout the body, while blocking the pain signals the brain delivers to the body. The act of taking the drug can be strongly reinforced by this release, making the user wish to repeat the experience.

This topic will allow us to gain a broader perspective of how psychoactive drugs affect not only people's health, but also the health system in different countries. For example, the management that governments have of certain medications and the use that is normally given to them to treat people's pain, which if not regulated, begins to turn into a dependency. There are many types of psychoactive drugs, which will be explained later. Each one generates different effects in people, and according to the dose, can even cause death. The

abuse of these drugs could imminently become a worldwide emergency if proper regulations are not followed. It is clear that many of them cannot disappear, because they bring benefits to medicine, but a balance has to be struck between the real needs of using them, without generating problems in the future.

4.2 Historical Background

The history of medicines is very broad, and it is not known with certainty who was the first to discover them. Throughout the years they have been used to cure or improve people's illnesses; especially plants have been the basis to obtain healing properties. Perhaps, myths have obscured the beginnings of drugs and medicine as well as their early history. The use of therapeutic herbs predates both ancient people and human civilization. Plants have played a significant role in maintaining human health and welfare. Since "drug" is derived from the French term "drogue," which means dry herb, it is clear that the earliest drugs were derived from plant sources. The earliest people employed many unusual methods to heal illnesses, relying on plants, animal products, and minerals, with plants receiving preference. Although there are significant differences between the ancient medical systems of the world, such as Chinese Medicine, Ayurveda, and Greek Medicine, they all agree that disease is caused by an imbalance among the components of the body, and that the goal of treatment is to restore the balance using herbs. (Narayana, 2007)

These are some historical backgrounds of various drugs that are used in the medical field:

- Morphine (1827): was derived from opium. Although morphine is considered an addictive pain reliever, some doctors feel that the benefits far outweigh the drawbacks. Morphine's discovery and widespread use opened the door for a new generation of over-the-counter and prescription pain relievers that we use today.

- Codeine (1832): Although codeine can be extracted directly from opium, the majority of it is derived from morphine, another opium derivative. Is a narcotic pain reliever and cough suppressant that works similarly to morphine and hydrocodone.

- Aspirin (1899): It was first synthesized from acetylsalicylic acid. As a blood thinner, it prevents heart disease and stroke, in addition to relieving pain.

- Methamphetamine (1919): is a highly addictive stimulant medicine that was created in 1919 for therapeutic use, but went on the market in 1938. It enables people to function continuously and stay alert while requiring less sleep. They are produced as pills, powders, or ice-like crystals.

- Fentanyl (1959): strong synthetic opioid medication authorized by the FDA for use as an analgesic (pain reliever) and anesthetic. As an analgesic, it is approximately 100 times stronger than morphine and 50 times stronger than heroin.

- Tramadol (1962): opioid pain reliever that is taken orally. Is most commonly used to treat moderate pain, such as dental care, osteoporosis, and neuropathy, in both acute and chronic contexts. It is also licensed for the treatment of cancer pain for periods of less than three months. It is a completely synthetic medication.

- Benzodiazepines (1995): medications that slow your brain activity and your nervous system. It tells your brain to release the GABA (gamma-aminobutyric acid), a neurotransmitter. It is used as an amnestic, anxiolytic, hypnotic and sedative medicine.

- Oxycontin (1996): brand name for the generic opioid oxycodone hydrochloride, an opiate agonist. It is used to treat moderate to severe pain caused by injuries, bursitis, dislocation, fractures, neuralgia, arthritis, and lower back and cancer pain.

National drug policies are bound by international law commitments. The three important accords influencing international drug legislation are:

- The 1961 United Nations Single Convention on Narcotic Drugs.

- The UN Convention on Psychotropic Substances of 1971.

- The United Nations Convention on the Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.

The United Nations drug control conventions are legally binding agreements that require governments to prohibit the distribution of banned drugs for non-medical or scientific purposes. This is a major impediment to national drug policy reform. The goal of these treaties is to create internationally applicable control measures that ensure psychoactive substances are used for medicinal and scientific reasons, while preventing their diversion into criminal channels.[25]

[25] The compilation of these three conventions is called "The International Drug Control Conventions", to have more information about its contents, see: https://www.unodc.org/documents/commissions/CND/Int_Drug_Control_Conventions/Ebook/The_International_Drug_Control_Conventions_E.pdf

4.2.1 WHO's Action

Within the UN system, WHO has played an essential role in addressing the global drug problem. WHO activities to combat the global drug problem can be classified into the following categories:

- " Prevention of drug use and reduction of vulnerability and risks;
- treatment and care of people with drug use disorders;
- prevention and management of the harms associated with drug use;
- access to controlled medicines; and
- monitoring and evaluation." (World Health Organization, n.d)

In addition, each country has its own national laws and regulations regarding the use of drugs in the manufacture, distribution, and use of drugs in pharmaceuticals.

The UN General Assembly's Thirty-First Special Session (UNGASS), in April 2016, reviewed progress in implementing the 2009 Political Declaration and Plan of Action on International Cooperation Towards an Integrated and Balanced Strategy to Counter the World Drug Problem, which included supply reduction and public health measures. (World Health Organization, n.d.)

4.3 Current Situation

According to a research made by the UNODC (United Nations Office of Drugs and Crime), around 284 million persons aged 15 to 64 took drugs globally in 2020, a 26% rise over the preceding decade. Young people are consuming more drugs than prior generations, with use levels in many countries being greater than in previous generations. People under the age of 35 make up a significant majority of those being treated for drug use disorders in Africa and Latin America. (UNODC, 2022)

The use of psychoactive substances by children and adolescents is a significant global public health issue that has an impact on the health of individuals, families, and the community at large. It has been shown that 66.1% and 65% of people had used psychoactive substances at some point in their lives. (Basha, 2023)

The use of psychoactive drugs and their impact not only on medicine, but on people's health has been seen recently around the world. This is an issue that must be addressed by the International Community. It's necessary to analyze how to mitigate, not only the effects on people, but also the consumption and the guarantees that a country offers or not.

4.3.1 Europe

The market for new psychoactive substances is distinguished by the huge number of substances that have appeared in this field, as well as the fact that new compounds are discovered each year. This phrase encompasses a wide range of substance kinds that are not regulated by international drug control treaties, while some may be subject to national regulatory measures. In 2021, EU Member States captured a record 8.5 tonnes of novel psychoactive drugs. (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2023)

Since the health effects of these unusual substances are frequently unknown, customers may be at risk for serious or even fatal poisonings or other health issues. The quantity of novel compounds of some medicines, such as fentanyl, seems to have decreased as a result of legislative constraints in Europe and non-EU source nations. However, new chemicals that are intended to circumvent laws' general definitions continue to appear, and China and India continue to be significant sources of these substances - or the precursors needed to make them. (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2023)

Although the use of injecting drugs has decreased over the past ten years in Europe, it still accounts for a disproportionate amount of the harm caused by illegal narcotics. Injections of other substances, including stimulants and medications, have been more widespread recently, either on their own or in combination with heroin or other opioids. Stimulant injection is linked to local HIV outbreaks in European cities, and it is associated with high-frequency injecting patterns of use. Poorly dissolved synthetic stimulants, drugs, or crack cocaine injections can significantly raise your chance of developing vascular damage or getting an infection from microorganisms. The danger of drug overdose can also rise with polydrug injection. Designing treatments to lessen the harm caused by this behavior requires an understanding of the harms connected to changing patterns of injecting drug use. (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2023)

While there have been reports of new synthetic opioids in Europe, and they may be spreading in some regions, their availability and use patterns now differ greatly from those in North America, with the majority of the northern and Baltic nations seeing the worst effects. The number of fentanyl-related deaths recorded in 2021 was about 140. However, it is believed that a sizable portion of deaths are linked to fentanyl which has been diverted from its intended medicinal purpose. Even if this number is probably underestimated, it cannot be compared to the tens of thousands of fentanyl-related deaths that were reported in North America over the same time period. (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2023). The following graph illustrates the amount of new psychoactive drugs reported in the European Union from 2005 to 2023, its trends show several fluctuations over those years.

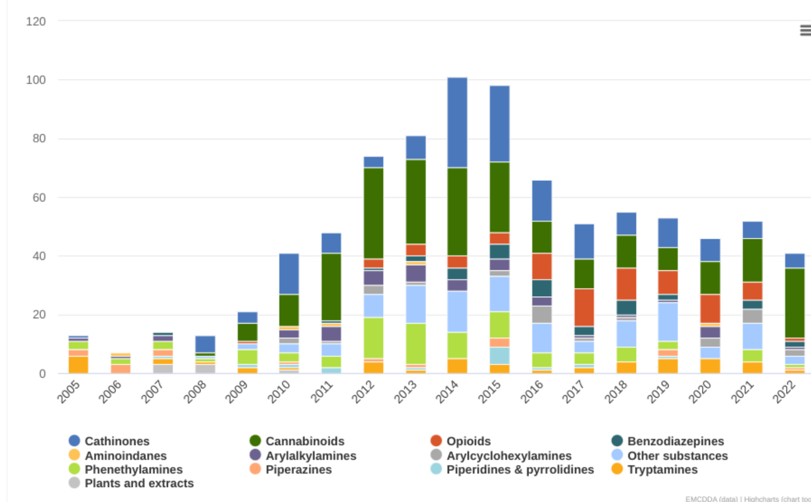

Figure 1

Number of new psychoactive substances reported for the first time to the EU Early Warning System, by category, 2005–2022 (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2023)

4.3.2 East and Southeast Asia

The price of methamphetamine has decreased to its lowest point in a decade as the supply has increased, according to the United Nations Office on Drugs and Crime (UNODC), and the synthetic drug market in East and Southeast Asia is continuing to grow and diversify. (Health Research Board, 2020)

Jeremy Douglas, the UNODC's representative for Southeast Asia and the Pacific, states:

> *"It is hard to imagine that organized crime has again managed to expand the drug market, but they have. While the world has shifted its attention to the COVID-19 pandemic, all indications are that production and trafficking of synthetic drugs and chemicals continue at record levels in the region." (2020).*

Because of the increased supply, methamphetamine has become less expensive, hitting its lowest price points in the recent decade across East and Southeast Asia. In 2019, methamphetamine prices fell in the high-profit markets of Australia, New Zealand, and the Republic of Korea. Despite falling prices, the purity of Southeast Asian methamphetamine remains high, and in some cases has even increased. (Health Research Board, 2020)

Dangerous synthetic opioids are gradually becoming more common, especially in East and Southeast Asia. While there were only three opioids found in the region's illicit drug supply in 2014, there were 28 by 2019. These regions should pay considerably more attention to synthetic opioids like fentanyl and even more dangerous variants.

Through the Global SMART Programme[26] and Mekong MOU on Drug Control[27], the UNODC is collaborating closely with Thailand and other nations in the region to monitor the drug situation, to offer guidance on cooperation, detection, precursor chemical control, and to design public health strategies. However, the most important action is to support countries in working together on joint and border operations. (Health Research Board, 2020)

4.3.3 Africa

The African Union continues to advocate for a multi-sectoral, balanced, and integrated approach to drug control through the African Union Plan of Action on Drug Control and Crime Prevention (2019-2023), taking into account global challenges relating to drugs, such as health, socioeconomic well-being, crime, terrorism, and security in our Member States. (African Union, 2019)

This plan was adopted in 2012, based on the UN Political Declaration and Plan of Action from 2009, as well as its balanced and integrated approach to supply, demand and harm reduction, and international cooperation. The new action plan is built on the foundation of the seven operational pillars of the Outcome document of the United Nations General Assembly Special Session (UNGASS)[28] on the global drug problem, which was held in 2016.

The new framework is also informed by three international drug control conventions: the Common African Position for UNGASS (2016); previous declarations and decisions of the Conference of African Ministers in Charge of Drug Control[29]; and more recently, the Specialized Technical Committee on Health, Population, and Drug Control[30]. All these emphasize on the principle of shared and common responsibility. (African Union, 2019)

Amphetamine-type stimulants (ATS) are the second most frequently abused drug category in Africa. Other narcotics used by children and youth in Sierra Leone and neighboring nations included benzodiazepines such as diazepam, chlorpromazine, and other

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[26] The Global SMART (Synthetics Monitoring: Analyses, Reporting, and Trends) Programme strengthens targeted Member States' capacity to generate, manage, analyze, report, and utilize information on illicit synthetic substances. It builds capacity in 11 East and South-East Asian countries: Brunei Darussalam, Cambodia, China, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand, and Vietnam; and it was expanded to Latin America in 2011.To visit their website, see: https://www.unodc.org/unodc/en/scientists/smart-new.html

[27] The Mekong Memorandum of Understanding (MOU) on Drug Control is the meeting of six East and Southeast Asian nations, such as Cambodia, China, Myanmar, Thailand, Vietnam and Lao PDR, to confront the threat posed by illicit drug production, trafficking, and use. To have more information about its powers and action plans, see: https://www.unodc.org/roseap/en/what-we-do/toc/mou.html

[28] To learn more about the Seven Chapters of the Outcome Document of the 2016 United Nations General Assembly Special Session (UNGASS) on the World Drug Problem, see: https://au.int/sites/default/files/newsevents/reports/36768-rp-aupa_on_drug_control_2019-2023_final_with_foreword_-_english_.pdf, page 14.

[29] To have a complete report of the ministers in these meetings, see: https://au.int/en/stc-health-population-and-drug-control

[30] To discover several news about the Specialized Technical Committee on Health, Population, and Drug Control, see: https://au.int/en/stcs/stc-health-population-and-drug-control

inhalants, with 3.7% injecting drugs.This usage poses a significant risk of infection with bloodborne viruses including HIV, hepatitis B, and hepatitis C, and sharing infected needles and syringes is a major mechanism of transmission for these viruses. (African Union, 2019)

4.3.4 Americas [31]

Due to the fact that the majority of the research in the report employs data from North America, there are few studies on drug use in the Latin American and the Caribbean region, and data gathering techniques are inconsistent.

However, multiple significant facts point to one conclusion that is imminent: drug abuse is a serious public health issue that has to be addressed right away. Inequalities in development, a lack of access to healthcare, and the isolation of some groups of the population from society are the three main causes of the issue. Consequently, a public health strategy must concentrate on: sustainable growth. the provision of healthcare as a fundamental human right. promoting social inclusion initiatives for vulnerable populations who are very susceptible to drug abuse and dependence. Drug usage has serious social and health repercussions that need to be addressed right now. (Pan American Health Organization, 2009)

4.3.5 WHO's Response

These have been some of the actions taken by who in order to control the abuse of psychoactive drugs and their effects on people's health[32]:

- Assisting nations in their initiatives to assure the appropriate use of opioids, their best possible availability for medical uses, and the reduction of their misuse and non-medical use. Also, a certain number of fentanyl analogues have been placed under international control, which implies that their distribution is subject to strict restriction. (World Health Organization, 2023)

- Helping countries to evaluate changes in drug use and related harm, in order to better grasp the impact of opioid dependence and overdose. (World Health Organization, 2023)

- Recommending that naloxone be made available to anyone who is likely to witness an opioid overdose, as well as training in opioid overdose management. First responders should focus on airway care, aiding breathing, and delivering naloxone in cases of suspected opioid overdose.

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[31] To have a complete perspective of the Americas' situation, see the Report on Drug use in 2019: http://www.cicad.oas.org/main/pubs/Report%20on%20Drug%20Use%20in%20the%20Americas%202019.pdf

[32] For more information about WHO response, regarding overdose, opioids, and people's health, see: https://www.who.int/news-room/fact-sheets/detail/opioid-overdose

Naloxone is an opioid antidote that, if taken in time, will reverse the effects of an opioid overdose. Is typically only available to medical experts, and even in medical settings, is still in short supply in many nations. On the other hand, some countries have already made naloxone available without a prescription in pharmacies, such as, Australia, Canada, Italy, the United Kingdom of Great Britain and Northern Ireland, and Ukraine; beginning a proactive distribution between the population. (World Health Organization, 2023)

- The "Stop Overdose Safely (S-O-S)"[33] Initiative was created in 2016, as part of the WHO/UNODC Programme on Drug Dependence Treatment and Care[34] to provide training on recognizing the danger of overdose and delivering emergency care in the event of an overdose. (World Health Organization, 2023)

4.4 Guiding Questions

1. What types of psychoactive drugs are the most common ones present in your delegation, and how has it affected factors such as people's health, the government and the economy?

2. Regarding your delegation's foreign policy, is it generally in favor of the access, use and distribution of psychoactive drugs? If so, how has it dealt with overdose cases, and how has it ensured that all people receive appropriate treatment?

3. Is your delegation part of any action plan, or does it plan to create one to prevent the misuse of psychoactive drugs in medicines? Does your delegation consider that the current action plans have not worked properly?; what would your delegation do to improve them?

4. Does your delegation think that a replacement for psychotic medications should be sought, even though they help stabilize certain patient conditions? In your delegation, what is the most widely used drug in pharmaceuticals; and what impact has it brought to the country?

5. Explain to what extent would your delegation consider only treating the problem directly by managing and reducing the use of psychoactive drugs? What welfare

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[33] For a broader perspective on WHO-UNODC "Stop Overdose Safely (S-O-S)" initiative, see: https://www.who.int/initiatives/joint-unodc-who-programme-on-drug-dependence-treatment-and-care/S-O-S-initiative

[34] To learn more about the objectives and main purposes of the UNODC/WHO Programme on Drug Dependence Treatment and Care; see: https://www.who.int/initiatives/joint-unodc-who-programme-on-drug-dependence-treatment-and-care#:~:text=The%20Joint%20UNODC%2DWHO%20Programme,drug%2Drelated%20harm%20to%20individuals%2C

conditions can your delegation offer to patients for the multiple consequences of the abuse of certain drugs?

6. How would your delegation justify the use of psychotropic drugs in medicines, and what measures would it be willing to take, so that only the health professionals have access to them, and can prescribe them according to people's needs? What impact would it have on your delegation, would it be positive or negative? Explain why.

4.5 Recommendations

Although this can be a broad topic, the most important thing is that you understand the differences between the types of drugs and their functions. On this basis, we want to focus on psychoactive drugs, which are the ones that have been misused lately for recreational purposes. It is important to take into consideration that many of them play an important role in medicine, and help patients to treat certain conditions. That is why they cannot be completely inhibited, but a way should be sought to limit them, either in their use, production or distribution. When evaluating the impact they have on people's health, do not only focus on the physical and mental conditions in which they find themselves, but also hopefully look beyond; observe what happens to the pharmaceutical companies, the government or even the economy of a country. This impact requires solutions, which can only be found if all the factors that can be affected are brought together for the benefit of all. We hope that you will research not only information from your own delegation, but also from other countries, so that you can begin to generate more support and validity in your arguments, as to whether you are for or against the problem, and how the international community responds to them.

4.6 Useful Links

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4.7 Glossary

- **Naloxone:** is a medicine that is used to quickly reverse an opioid overdose. is an opioid antagonist, which means it binds to opioid receptors and has the ability to reverse and prevent the actions of other opioids. Is a short-term therapy for opioid overdose, with short-term effects. As a result, it is vital to seek medical attention as quickly as possible after delivering or receiving naloxone.

- **Neurotransmitter receptor:** A neurotransmitter-activated membrane receptor protein that allows communication with other cells via chemical signals.

- **Overdose:** is when you consume an excessive amount of a substance or medicine. It is crucial to remember that not all overdoses are fatal or life-threatening; however, if an overdose is suspected or has happened, medical help should always be sought.

- **Substance abuse:** consumption of alcohol and illegal drugs, as well as other psychoactive substances, that are harmful or dangerous. The adverse effects on people's health that illicit drug usage has on society are one of its most significant effects. Additionally, drug usage costs individuals, families, and society a significant amount of money.

5. Country List

I. Bolivarian Republic of Venezuela
II. Democratic Republic of the Congo
III. Dominican Republic
IV. Federal Republic of Somalia
V. Federative Republic of Brazil
VI. French Republic
VII. Hellenic Republic
VIII. Islamic Republic of Afghanistan
IX. Italian Republic
X. Kingdom of Saudi Arabia
XI. Kingdom of Spain
XII. People's Republic of China
XIII. Republic of Colombia
XIV. Republic of Germany
XV. Republic of South Sudan
XVI. Republic of the Union of Myanmar
XVII. Republic of Türkiye
XVIII. Russian Federation
XIX. State of Libya
XX. Syrian Arab Republic
XXI. The Republic of South Africa
XXII. The State of Eritrea
XXIII. Ukraine
XXIV. United Kingdom of Great Britain and Northern Ireland
XXV. United States of America

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