TOPIC A: Narcotics Trade in South America

Overview

For several decades, the Andean Region has maintained its status as the largest cultivator and trafficker of cocaine in the world. The main Andean narcotics industries are found in Colombia, Peru, and the Plurinational State of Bolivia.\(^1\) Bordering one another, these three nations contain similar geographical features, in particular the Andean slopes, which provide ideal conditions for the coca bush. This explains the abundance of the coca crop.\(^2\)

The primary consumers of cocaine are located in the industrialized nations of North America and Europe, and thus cocaine is often transported overseas or by land. Cocaine found in North America is generally traced back to Columbia as its origin, with Mexico or Central America acting as transit countries, while Peru and the Plurinational State of Bolivia are currently the largest providers of cocaine for European consumers, transporting cocaine across the Atlantic.\(^3\)

Despite enormous efforts made to eradicate the drug market through seizing drugs and destroying crops, production levels have only experienced slight fluctuations and remain quite high. Incredible technological advances and global expansion of the narcotic market have made seizing and tracking cocaine increasingly difficult. More importantly, the combined forces of corruption and intimidation have allowed governments to slacken regulations; therefore, the UNODC must act accordingly to ameliorate this ever-growing predicament.\(^4\)

Timeline

\(^1\) http://www.unodc.org/unodc/en/treaties/index.html\?ref=menuside
\(^3\) Ibid
\(^4\) http://www.drugfreeworld.org/drugfacts/cocaine/a-short-history.html
C. 3000 B.C – The coca leaf is most likely consumed for the first time.
1532 – Spanish soldiers invade Peru, and the Spanish use cocaine as a means to better exploit and control Indian laborers in Spanish mines.
1880s - Numerous companies succeed in creating cocaine hydrochloride, a concentrated version of the coca plant that took the world by storm.
1884 – Sigmund Freud, a young physician in Vienna, publishes “Über Coca,” further promoting cocaine as a positive drug, and encouraging the use of cocaine as a topical painkiller.
1903 – Cocaine is no longer used in the soft drink Coca-Cola.
1914 – Congress passes the Harrison Narcotics Act. Nonmedical use of cocaine is banned in the U.S.A, and the importation of cocaine and coca leaves (outside of pharmaceutical use) is prohibited.
1970s – Colombian drug traffickers begin to organize an intricate network for the purpose of smuggling cocaine into the US.
1990s – Colombian drug cartels produce and export between 500-800 tons of cocaine annually, and globalize their market to Europe and Asia.
1991 – Cartel lawyers under Colombian drugs kings rewrite portions of the national constitution to outlaw extradition for six years.
2000 – U.S.A and Colombia enact Plan Colombia, a crop-spraying program to destroy Colombian coca crop.
2008 – Cocaine becomes the second most trafficked illegal drug in the world.
2009 – Colombia becomes the world’s largest cocaine producer, accounting for 43% of global coca cultivation.
2010 – Peru surpasses Colombia in potential pure cocaine production, making Peru the largest source of cocaine in the world.

Historical Analysis

Cocaine is extracted from the leaf of the Erythroxylon coca bush, which grows almost exclusively in South America. The coca leaf’s abilities to boost energy relieve fatigue, and dull hunger and cold have long been known to the Andeans, who have likely been chewing them for thousands of years. In 1859, cocaine was first isolated by Albert Niemann, and by the 1880’s its popularity as an anesthetic rose rapidly in the medical community. Despite several reports of addiction and even death, positive publicity overshadowed the negative, and the drug’s popularity continued to soar even beyond the realm of medicine.

It was not until the early 1900s when the severity of the potential harm of cocaine was seriously considered by society. As a result, the nonmedical use of cocaine was prohibited in the US with the passing of the Harrison Narcotics Act in 1914; however, a mere few decades later, the acute...
consequences of consuming the drug were forgotten, and being a cocaine user in 1979 was seen as "rich, trendy and fashionable."\textsuperscript{16}

With the resurgence of cocaine usage, Colombian traffickers began smuggling small quantities to the US, which quickly accumulated them astounding profits. This flourishing and lucrative trade was controlled by cartels, notably the Medellin Cartel, led by Pablo Escobar, and its arch-rival the Cali Cartel, headed by the Rodriguez Orejuela brothers.\textsuperscript{17} The emergence of these cartels led to larger cocaine shipments to the US, earning significant amounts of wealth and power for the leaders. In the 1980’s, Escobar, fearful of facing trials in the US, revolted against the government in an attempt to outlaw extradition, declaring: “better a grave in Colombia than a jail in the USA.”\textsuperscript{18} When this attempt failed, the drug king unleashed terror on the country, ordering the assassination of political figures, police, and prosecutors, the abduction of socialites, and other violent deeds. With similar objectives in mind, the Cali cartel bosses sought to entice politicians with irresistible offers including money, and women. Eventually, democracy submitted to corruption and fear; extradition was outlawed for more than six years, and not restored until December 1997.\textsuperscript{19} The cartels’ businesses continued to thrive until their respective leaders were either killed or turned in to the police.

The destruction of the cartels did not annihilate the trade, however - it merely fragmented it. Smaller, more controllable groups were established, and each with distinct tasks; one group was responsible for smuggling, another for controlling labs, and yet another for transportation.\textsuperscript{20} In comparison to the large cartels, smaller organizations were much more difficult for the US and Colombian officials to tackle and track down. Furthermore, well-known ties with both political and military organizations serve as a major hindrance to the eradication of the cocaine trade.

**Current Situation**

Virtually all of the world’s cocaine is produced in the three Andean countries: Colombia, Peru, and Bolivia. With decades of experience in producing and transporting the drug, Andean producers and traffickers have become even more efficient and adept in the past several years, continuing to profit greatly despite heightened eradication efforts in each respective nation.\textsuperscript{21} The main consumers of cocaine are generally industrialized nations such as Brazil and several European countries, and the largest consumer is the United States. For the drug to arrive at these destinations, traffickers pass through many transit countries, most notably Mexico, Brazil, Belgium, and Spain, where cocaine seizures act as supply indicators and are the most concentrated. The main issue of the Andean trade, however, is not necessarily centered on how to eradicate cocaine trafficking in the concerned states; obstructing drug production in one region results in its reappearance somewhere else.\textsuperscript{22}

Since the destruction of the Cali and Medellin Cartels, the cocaine trade has continued to operate with a highly efficient production process. Colombia is believed to contain over 300 active drug organizations, while Peru’s Ene-Apurimac valley (VRAE) is the world’s densest coca-producing belt.\textsuperscript{23}

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\textsuperscript{17} http://www.drugfreeworld.org/drugfacts/cocaine/a-short-history.html
\textsuperscript{18} http://www.gypsylounge.com/x/sam/history_lesson/col2.htm
\textsuperscript{19} http://edition.cnn.com/2012/01/18/opinion/rempel-colombia-extradite-cartels/
\textsuperscript{20} http://www.pbs.org/wgbh/pages/frontline/shows/drugs/business/inside/colombian.html
\textsuperscript{21} Ibid
\textsuperscript{22} http://www.economist.com/blogs/economist-explains/2013/04/economist-explains-why-colombia-produces-less-cocaine
Peru has recently surpassed Colombia as the world's top grower of the coca crop, with a total of 49,800 hectares as of 2013; Colombia, with 48,000 hectares of coca plantations, is the second largest grower. The world's third largest grower is Bolivia, with 23,000 hectares of coca cultivation. Despite a decline of 14 per cent from the previous year’s estimates in the coca bush cultivation of these countries in 2012, the improvements in the efficiency of the cocaine manufacturing process reduces the significance of this decline. Furthermore, according to data from the UNODC, despite doubled eradication efforts in Peru in the years 2000-2010, the amount of land used for coca cultivation has expanded by nearly 50 percent. These unexpected rebounds have also been observed in Colombia and Bolivia in recent years, suggesting that relying on eradication alone is insufficient to cut coca crops. However, intermittent rebounds and signs of leveling-off in cocaine production have been paralleled by aggressive eradication efforts in all three Andean countries. In Peru, the government eradicated 23,600 hectares of coca crops in 2013, exceeding the country’s target by roughly thirty percent. Similarly, the neighboring Colombia also eradicated an impressive total of 70,000 hectares in 2013, although it failed to reach its initial target. While eradication efforts may seem auspicious, any further advancement in the process of destroying coca plantations will be restricted greatly by external factors, notably guerrilla attacks, and social movements concerning coca farmers.

With a 1.8 per cent annual prevalence rate, North America is the largest destination for Andean cocaine. The primary North American consumer of cocaine is the United States, where most cocaine shipments, if not all, originate from Colombia and enter the country via transit country Mexico. The alarming rates of cocaine use in the United States have triggered strong law enforcement efforts from the government, which have hindered Colombian trafficking activities and therefore reduced the availability of the narcotic in the country. Cocaine seizures rose from 89 tons to 106 tons from 2010-2011, while between the years of 2012 and 2013, a declining trend was observed. However, the estimated prevalence of cocaine use in the population aged 12 years or older rose from 1.5 per cent in 2011 to 1.8 per cent in 2012, proving that the United States is still indeed an active consumer of cocaine.

South America (including the three coca growing nations) and Europe are also major destinations for cocaine and are the world’s largest consumers of cocaine after North America. In 2008, South America and Europe were estimated to have roughly 2.3 – 2.4 million users and 4.5 – 4.9 million users (users concentrated in Western/Central Europe), respectively. The trafficking route to Europe passes through many transit countries, which provides many opportunities for the drug to be exposed to the general population of a transit region. A prime example of this can be seen in Brazil, a South American country that has become extremely vulnerable to cocaine consumption and trafficking due to its geographic location.

UN/International Involvement

As the largest consumer of cocaine in the world, the United States has been taking major courses of action to fight the drug trade since the early 2000’s. The world power has supported Peru and Colombia in eradicating and controlling the narcotic trade. The most notable operation the United

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24 Ibid
25 Ibid
28 Ibid
30 Ibid
31 http://methoide.fcm.arizona.edu/inocenter/index.cfm?stid=168
States has undertaken is Plan Colombia, a six-year eradication campaign that planned to “end Colombia’s internal conflict, eliminate drug trafficking, and promote economic and social development”. The United States provided Colombia with over $1.3 billion in military aid, and also crop-dusters and helicopters to perform aerial spraying over Colombia’s coca crop. Plan Colombia has dramatically improved eradication efforts since its formation; however, it has received much criticism from both Colombian and American politicians, and is an extremely controversial operation for reasons pertaining to health and the economy.

Apart from the United States, there has been little involvement in fighting the drug trade in the international community. Nations that have recognized the danger of the situation have at most taken local action that does not directly affect the trade. To achieve the complete eradication of the illegal cocaine trade, it is integral for the international community not only to support the Andean nations, but also be directly involved in the combating this illicit trade.

The United Nations first formally addressed the issue of narcotics at the Single Convention on Narcotic Drugs held in 1961. The convention paved way for the creation of three major treaties. The treaties focus on methods to ensure the preservation of narcotics for medical and scientific purposes while prohibiting their entering into illicit trades. In regards to illicit crop monitoring, the UNODC, in cooperation with the national monitoring systems of Colombia, Peru, and Bolivia, decided to create annual surveys that continue to assist these states in managing illicit crops. The surveys provide accurate and comprehensive data that lucidly present the current situation. Although there are many UN based operations and projects that target the illicit drug trade, there are very few operations among them that have made significant contributions towards the eradication of the Andean cocaine trade.

Possible Solutions and Controversies

As previously mentioned, eradication plays a key role in combating the Andean cocaine trade. Colombia, Peru, and Bolivia currently all have major eradication plans that strive to hinder growth and production of the narcotic industry, destroying crops through either manual eradication or methods of spraying. The destruction of coca plantations may seem to benefit the Andean region, but in reality, it triggers many conflicts to surface.

The drug trade provides jobs for many people either in the growing, trafficking, or selling process of the trade. In other words, the depletion in coca crops immensely affects the lives of many workers. Most laborers working in the drug trade have held their jobs for a long period of time. They are therefore unwilling to abandon their current post as long as consumers and profit remain strong. When faced with a rapid termination of the trade, these workers are extremely vulnerable to unemployment and poverty; thus, it is crucial for local governments and the global community to consider the future and wellbeing of the people involved in the local economies while working to end of the drug trade. An act to decriminalize coca farmers or low-level producers may be appropriate to address this conflict.

33 Ibid
35 http://www.unodc.org/documents/wdr/WDR_2010/2.3_Coca-cocaine.pdf
36 http://www.cnn.com/2012/01/18/opinion/rempe -colombia-extradite-cartels/
37 http://www.huffingtonpost.com/2012/06/24/peru-cocaine-production-global-drug-conference_n_1622467.html
38 http://www.drugfreeworld.org/drugfacts/cocaine/a-short-history.html
Human health is also of concern as eradication efforts trudge on full speed. In Colombia, the primary method of coca eradication is through aerial spraying. Clouds of weed killer are constantly sprayed from helicopters and crop-dusters, covering tens of thousands of hectares of drug plantations. Long-term exposure to these chemicals can be toxic to human health as well as food crops. Authorities may seek to find alternative methods of eradication; however, manual eradication, which Bolivia and Peru prefer, has its own set of problems. Manual eradication is extremely dangerous, especially in areas such as Peru’s VRAE where a large percentage of coca grown territory is controlled by a guerilla group, and can put police forces’ lives in jeopardy. Clearly, amendments can and should be made towards these eradication procedures. However, simple changes cannot resolve this problem, as factors are widely ranged - professional and expertise assistance is required.

Similar to other illicit trades, the Andean trade involves three parties - the Andean nations as producers, the transit countries, and the consumer countries. In order to address this issue, authorities must develop a holistic approach that encompasses all three parties. The producer nations are all currently pressuring the development of plantations with aggressive eradication plans; however, drug lords and guerilla groups are nothing but uncommon in dense production areas, making these areas inaccessible and dangerous. In addition, drugs lords and gangs are known to be affiliated with politics and governments, using their power and wealth to win favors. In addition, the workers within the drug trade must also be taken into consideration – these workers will be unwilling to leave the illicit trade (most workers have very little opportunity in finding other work) unless better alternatives are offered.

Transit countries are an integral element of the cocaine trade. These countries are often faced with relatively high consumption of the drug and weak security as a result of trafficking. It is evident that stronger border security and regulations should be established, though this does call upon the assistance of the international community. With the abolishment of drug transport in these countries, the drug trade will be greatly affected if not completely annihilated. As the drug is transported globally, a combined international effort to monitor borders is required, and the involvement of NGOs is also appropriate here.

Consumer countries, as previously stated, tend to be large, industrialized countries that are influential and wealthy. These countries play a huge role in destroying the drug trade, as they are financially able to fund projects, supplies, etc. to assist producer countries. Furthermore, these countries must raise awareness of the current issue and also offer proper treatment to addicts who otherwise would be undoubtedly left in a difficult state with the eradication of the trade. Undoubtedly, this issue cannot be solved with a single project; it requires a combination of efforts from different areas of assistance that are consistent over a period of time.

Bloc Positions

40 Ibid
41http://www.economist.com/node/719423
Andean Region

Virtually all the world’s cocaine originates from the three countries in this region. However, apart from Colombia, the international community has contributed little to alleviating the situation. On the other hand, Colombia has received great assistance from the United States in terms of eradication equipment and more than one billion dollars worth of monetary support. Peru, Bolivia, and Colombia are making great efforts in terms of preventing the drug trade within their own borders, and all share a common goal of the complete cessation of the drug trade, with or without external aid.

South America

Apart from the Andean cocaine trade, South America is also a major hub for other illicit trades. For example, Mexico’s drug situation has been receiving much attention from the international community recently. As a result of cocaine production in the Andes, countries that are geographically near, such as Brazil, and Mexico, naturally play large roles either as transit countries or staging areas. Furthermore, as cocaine is relatively easy to attain in this region, statistics show that cocaine use has in fact risen over the past years. These countries are familiar with drug trafficking and clearly, and have often received international assistance to appease drug trades within their borders.

United States of America

The United States is currently the largest consumer of cocaine and the largest source of international aid to the Andean region and South America, particularly in Colombia and Mexico. The United States is in accord with the governments of Andean countries, and wishes to see the end of the illicit trade. The United States has also been active in many narcotics trades, such as drug trafficking in Afghanistan, proving it to be a willing and strong source of foreign aid. The United States is likely to continue supporting the Andean region in the war on drugs.

Western and Central Europe

The countries in this area consist not only of major consumer countries but also transit countries that are integral to the structure of trans-national trafficking. These countries have shown minor involvement in the issue; nevertheless, these countries wish to put an end to the trade, as usage rates have remained at a concerning level.

Central Asia

Many countries in this area have been and still are battling drug trafficking, most notably the opium and heroin trade. Large amounts of heroin and opium primarily originating from Afghanistan pass through these countries, worsening the existing conditions of unstable national security. These countries, although situated far away and uninvolved in the Andean trade, are working towards preventing drug trafficking in their respective countries, and thus would have suitable suggestions for

43 http://www.unodc.org/documents/wdr/WDR_2010/2.3_Coca-cocaine.pdf
46 http://www.economist.com/node/719423
Discussion Questions

1. What are some short term and long-term solutions that work as compliments to mollify the current situations?
2. How can national sovereignty be respected even in international plans that tackle drug trafficking? (E.g. policies, projects, etc.)
3. How can the UNODC approach the issue of drug lords and gangs in a peaceful manner?
4. What are effective ways to attend to the needs of the people involved in the trade, such as coca farmers, addicts, dealers, etc.?
5. How successful have past efforts been in averting other drug trafficking cases? What can be improved? What has been constructive? What has been futile or is now obsolete?
6. Should the UNODC be permitted to work within the local government? To what extent?
7. What effects will neighboring countries experience in the wake of a gradual reduction in cocaine production in the Andean region? Is it positive, negative, or both?

Additional Resources

UNODC World Drug Report – Cocaine: Overview

PBS Overview on the Colombia Drug Trade

Article on Peruvian Cocaine Trade

Official UNODC Website
http://www.unodc.org/unodc/index.html
Bibliography


PBS. PBS. Web. 27 June 2014.


Topic B: Counterfeit Medicine

Overview

As defined by the World Health Organization, a counterfeit medicine is one which is deliberately and fraudulently mislabeled with respect to identity and/or source." ¹ Although closely related, the term ‘counterfeit medicine’ is not to be confused with ‘substandard pharmaceutical’, which is the term identifying medicines that are manufactured below established standards of quality. Fraudulent drugs are extremely dangerous to human health, and in some cases, these drugs can even be deadly. These types of drugs may contain incorrect doses of active ingredients, the wrong active ingredients, or none at all. In some cases, even toxic substances, such as rat poison, have been found in certain fraudulent medicines.² Although the production and trafficking of fake, substandard drugs have been prevalent over the past decade, they remain an underreported issue in both developing and developed countries. Indeed, governments and pharmaceutical industries are reluctant to publicize problems regarding the quality of their respective drug supplies, and this secrecy keeps the public and consumers in oblivion.

While it is important to direct attention towards the health aspect of this situation, the prosecution and criminal justice aspect of this issue cannot be overlooked. The counterfeit medicine trade is a massive industry, with sales of five billion per year from East Asia and the Pacific to South-East Asia and Africa alone.³ This extremely lucrative, ever-growing, and somewhat low risk trade has attracted many organized criminal groups; in the past decade, groups such as the Russian mafia, Colombian drug cartels, Chinese triads, Mexican drug gangs, and even the Hezbollah and al Qaeda, were known to have been heavily involved in the producing and trafficking of fraudulent drugs.⁴ It is the involvement of these mature crime groups that makes eradicating and uncovering this trade immensely difficult and dangerous. In addition, many consumers of these counterfeit drugs, especially those in developing countries, buy from black market sources simply because they are unable to afford more costly prescription drugs. It must be taken into consideration that the cessation of this trade may cause damage to a large group of people.

The pharmaceutical industry is also deeply affected by this illicit trade, losing hundreds of millions in profit due to unregulated production of seemingly identical products; however, this industry is often reluctant to publicize cases of fraudulency in fear of further damaging sales and the industry’s reputation. With obvious issues in the pharmaceutical industry, the UNODC must address this global issue with none other than a global solution.

Figure 1: Counterfeit drugs at a market in Ouagadougou, Burkina Faso.
Photo: IRIN/Brahima Ouedraogo
Timeline

1985 – Counterfeit medicines are first mentioned as a global problem at the WHO Conference on Rational Drug Use in Nairobi, Kenya.
1992 – First international meeting on counterfeit medicines is held at WHO in Geneva, and a definition of “counterfeit medicine” is agreed on.
1995 – Inoculation of fake vaccines causes 2500 deaths during a meningitis epidemic in Niger; more than 50,000 people were inoculated with the vaccine.
2003 – The UN Convention against Transnational Organized Crime (UNTOC) is created.
2006 – The International Medical Products Anti-Counterfeiting Taskforce (IMPACT) is launched in 2006 by the WHO, UNODC, and Interpol.
2006 – Zyprexa, a drug to treat bipolar disorder and schizophrenia, is detected in the legal supply chain of the United Kingdom; the drug lacked sufficient active ingredient.\(^5\)
2007 – The top drug official of China is executed for approving untested medicine in return for bribes.
2008 – Heparin, an anticoagulant used to treat blood clots in veins, arteries, and lungs, is distributed in twelve countries in a counterfeited version, causing eighty-one deaths in United States, and more than sixty-eight deaths outside of the U.S.\(^6\)
2009 – More than two million counterfeit insulin needles, claimed to be from Iran, are found in Netherlands, Poland and the United Kingdom.\(^7\)
2009 – Simon Martin Hickman is sentenced to imprisonment after the United Kingdom’s Medicine & Healthcare Products Regulatory Agency (MHRA) seized £14.4 million of his assets from dealing counterfeit medicine.
2010 – Police in Spain intercept 160,000 fake Viagra pills. Viagra is amongst one of the most commonly found drugs in the illicit pharmaceutical trade.\(^8\)
2011 – Resolution 20/6 is adopted at the 20\(^{th}\) session of the Commission on Crime Prevention and Criminal Justice.
2012 – Angola Customs agents seize 1.4 million packets of counterfeit Coartem, a Malaria medication produced by Novartis.
2012 – Johnson & Johnson is ordered to shut down a plant in Fort Washington, Pennsylvania due to improper marketing of antipsychotic drugs. This is the third plant the drug maker has closed since 2010.

Historical Analysis

Counterfeit medicine is one of many crimes grouped under a much larger industry known as organized crime, or transnational organized crime. The many illicit trades included in transnational organized crime amount to a grand total of hundreds of billions of dollars each year. Although the trafficking of counterfeit medicine only accounts to a small percentage of profits in the entire organized crime business, it has been and continues to be one of the most dangerous, and health-threatening trades to the global community.

Since its first recognition as a global problem in 1985, counterfeit drugs have always remained, to a certain extent, in obscurity; there has been no global study carried out pertaining to them, and a universally accepted definition has only been created in recent years, making the true extent of the issue unknown\(^9\). The lack of an internationally accepted definition has acted as a major obstacle to prosecutors and investigators, and criminal groups have taken advantage of such loopholes. Furthermore, the reluctance of the international community to recognize counterfeit medicine as a serious issue until the early 21\(^{st}\) century prevented earlier establishment of regulations and international treaties. Some even argue that the absence of international recognition has encouraged the massive growth of the industry.
It is important to understand that counterfeit medicine has been seen as a national and international threat to human health and security only recently. Thus, there has been little involvement in the cessation of its trade and production from organizations and UN bodies until the past decade. Even with the emergence of stricter regulations, the groups active in this trade have developed highly sophisticated and clandestine means of producing and transporting these drugs. The clandestine nature of the trade has also contributed to its history of scarce, untraceable data. In addition, because the illicit trade has been developed only over a few decades, involved groups were able to fully take advantage of incredible technological advancements. Counterfeit medicines have been a global plague since their existence, and their production and distribution has linked together every country in the world, whether developed or developing. Although counterfeit drugs are prevalent globally, Asian countries have typically shown higher production levels when compared to the rest of the world. Despite being one the most harmful trades in existence, only recently have counterfeit medicines been publicized as a prevalent threat to global security and human health.

**Current Situation**

The counterfeit medicine trade has seen significant growth over the past few years. As previously mentioned, global circumstances have greatly contributed to its growth. Although measuring the magnitude of counterfeit medicines is extremely complex as it is nearly entirely underground, various national and international organizations have tried to collect data to reflect the industry at large. According to the Centre for Medicine in the Public Interest, counterfeit drug sales hypothetically generate 75 billion USD globally in 2010, an increase of ninety-two per cent in respect to 2005. Percentages of counterfeit medicines in national pharmaceutical markets vary from as high as fifty percent to as low as one percent, with higher percentages generally pointing to less developed countries and economies in transition, while the lower percentages refer to the developed countries. It can be interpreted from these statistics that although counterfeit medicines affect the global population, the issue is more prevalent by far in poorer, more unstable regions. Indeed, the WHO says that one in ten drug products in poorer nations are fake, and as much as thirty percent of medicines in parts of Asia, Africa and Latin America could be fraudulent. However, this does not at all undermine the severity of the issue in developed nations; cases of counterfeit medicines appearing in local pharmacists are frequent, and drugs developed in industrialized countries are often the most commonly counterfeited drugs.

There are many factors that attract criminal groups to join the trade and cause it to thrive. Firstly, there is and has always been a high demand for pharmaceutical drugs, and there are always patients looking for cheaper alternatives to expensive prescription drugs. For instance, in India and China, Viagra costs $60/kg, while in the US, the same amount packaged in 25mg tablets would sell on prescription for up to $200,000. For a poor family barely able to scrape by, especially in developing countries, purchasing drugs and medicines from the black market is simply one of the only alternatives to the deaths of loved ones. Moving on, the industry involves low cost production, and the profits are huge. Sophos, a British security software firm, stated that it was possible to earn an average of $16,000 per day working on a criminal organization network outside of Russia. In addition, the low risk of detection and prosecution allows even homegrown counterfeiters to be able to profit from the illicit trade. A lack of enforcement and prevention measures by officials, and the existence of many loopholes within the criminal laws also encourage many to take part in the business. Moreover, the penalties for counterfeiting non-medicinal products tend to be much more severe than that of counterfeit medicine. Another factor contributing to the success of the trade is the secrecy of the pharmaceutical industry; despite often being the first to identify cases of fake drugs, pharmaceutical companies cover them up to protect the reputation and profit of their market.
It is noteworthy to mention that the regions most affected by counterfeit medicines are where fragile economies, widespread poverty, absence of regulation, and weak security measures exist. It is estimated that fake drugs represent more than fifty per cent of the pharmaceutical market in several African countries. This is extremely worrying as unstable areas are also where contagious diseases and sickness are pressing issues. With the frequent use of counterfeit drugs, the risk of death and widespread drug resistance become much higher. For example, in Africa, the continent that suffers most from the presence of counterfeit life-saving medicines, up to forty percent of anti-malaria products would contain no active ingredient, thus having no effect in combating malaria. These drugs are often shipped over from South and East Asia, where counterfeiters target unstable regions. It is noteworthy to mention the lack of audits in less developed countries, which could greatly help to achieve a much-needed comprehensive understanding of this issue.

Data indicates that countries in Asia report the largest share of counterfeits detected globally. The largest producers are China and other countries of South and Southeast Asia, with Nigeria, Russia, Mexico, Brazil and Latin America being other major producers. Many of these countries have developed methods of sophisticated operations and have reached great pharmaceutical manufacturing capabilities. As they develop their own internal manufacturing capabilities, these countries are also becoming the largest producers of fake medicines because of a lack of regulation compared to the West. These products may pass through numerous areas during their transportations before reaching their final destination, thus exposing the counterfeits to multiple areas. However, there are also multiple studies proving Western markets to be active in packaging counterfeits, substandard and gray pharmaceuticals. The production and manufacturing process of counterfeit drugs is quite nebulous, though it is clear that the efficiency and quality are the last things that matter for drugs counterfeiters.

International Involvement

In the past years, the WHO’s efforts towards the control of counterfeit drugs have been the most prominent. Nevertheless, as the counterfeit drug trade's influence in organized crime became increasingly worrying, the UNODC began to contribute more to prevention efforts. The main UN operation conducted by the UN dedicated towards combating counterfeit drugs is the International Medical Products Anti Counterfeiting Taskforce (IMPACT), which was jointly launched in 2006 by the WHO, UNODC, and Interpol. The joint actions aim at “raising awareness about the danger of falsified medicines”, and “tackle the enforcement of laws”. The IMPACT remains active today.

Europe has worked towards providing safe quality medicines through organizations such as the Council of Europe/EDQM. The EDQM standard for safe medicines and their safe use are recognized worldwide, and legally binding in member states. The EDQM works in partnership with many international, regional, and national agencies in protecting public health.

Other than the few established organizations and operations, prevention efforts have been predominantly within national borders if any at all. Because of the lack of sufficient data and other problems, many states, especially developing and unstable areas, are unable to enforce regulations. This issue cannot be solved with regional efforts; the illicit trade must be countered with an international approach, as it is a transnational organized crime that reaches out to virtually every existing country. Thus, it is crucial that more countries participate in the fight against counterfeit drugs.

Possible Solutions and Controversies

A major controversy in this regard is the lack of a mutually agreed-upon definition of the use of the
term “counterfeit”. Though this may seem like a petty issue at large, a proper definition is crucial to the process of identifying and addressing the issue. According to a report published in 2013, there are only two countries that have a clear legal definition of what a counterfeit medicine is: the Philippines and the United States of America. The lack of an accurate and clear definition can lead to lax regulations and even confuse the many different activities related to counterfeiting. For example, it is easy to confuse the trafficking of false active pharmaceutical ingredients, which are the raw materials found in a pharmaceutical product, with the trafficking of counterfeit drugs. This issue can be resolved with a universally accepted definition of the term. Although the WHO has included a general definition of “counterfeit drugs” in its recent reports, multiple parties have differing opinions on the exact meaning of counterfeit. Some see the word counterfeit as strictly an intellectual property (IPR) issue, almost always referring only to falsely packaged products that violate trademarks.

As previously mentioned, less developed countries generally suffer the most from counterfeit drugs. They house many impoverished people who are very sensitive to the price differentials between identical products, and would undoubtedly select a cheaper alternative drug. In addition, in the rural areas of less developed countries, communities are cut off from the official supply chain of pharmaceutical products; in this case, there are essentially no alternatives to consuming fake medicines. In dealing with these less developed countries, education and raising awareness are extremely crucial towards shutting down this illicit business.

Other than patients and consumers, the entire pharmaceutical sector is also greatly affected by the prevalence of the trafficking of counterfeit medicine. Manufacturers who produce legitimate products suffer greatly as counterfeitors make copycat medicines that abuse brand names. This leads to significant losses in profits in the legitimate pharmaceutical industry. For instance, in 2005, it was reported that the US’s national pharmaceutical market experienced a loss of approximately forty million USD due to the surge of counterfeit medicines. Moreover, the counterfeit drugs trade causes damage to not only the marketing policies but also the credibility of each pharmaceutical firm. However, drug companies are often unwilling to bring the spotlight upon counterfeit cases, as they believe this will further damage their company’s credibility. In general, counterfeiting causes pharmaceutical companies loss of profit, undermines their Research and Development (R&D) efforts, and cripples their marketing strategies and credibility. For these reasons, pharmaceutical companies must actively cooperate with government and international agencies to fight against counterfeit manufacturers.

It is not possible to solve this issue with a single approach. However, alleviation can be achieved through several methods. Shutting down counterfeit markets, along with their producers, traffickers, and salesmen, around the globe must be a top priority for all affected regions. To do so, stricter laws and regulations must be enforced in order to execute proper criminal prosecution. More specifically, since counterfeit drugs are a global issue, nations must cooperate in strengthening border controls and in grasping a clear understanding of their nation’s and other nations’ current situations in order to effectively combat the trade. In targeting less developed areas, educating citizens on counterfeit drugs and raising awareness of the severity of the issue is crucial in protecting the health of those who are regularly exposed to fake medicines. Raising awareness of counterfeit drugs should not only be restricted to rural areas, however, as fake medicines are extremely underreported when compared to other global issues. It is important to understand that counterfeit medicines are an issue of international dimensions. They are also a business that is controlled largely by organized crime groups, thereby making it an emerging transnational organized crime. With that in mind, solutions must consider a global perspective, though regional efforts are also important. In general, the insufficient amount of data greatly hinders any preventative measures; therefore, the international community must first work on gaining a more comprehensive understanding of the issue on a global scale.
Bloc Positions

Africa

African countries are most affected by counterfeit drugs. As previously mentioned, the illegal production, sale and distribution of fake drugs are estimated to represent more than fifty per cent of the pharmaceutical market in several African countries. This is extremely alarming as in some regions, the only pharmaceutical products that are accessible are from the illicit trade. These countries are also areas where medicines that counter fatal diseases such as malaria and AIDS are most needed, thus the growing influence of counterfeit drugs will certainly put human health in danger. African countries are most likely in need of and are accepting of international assistance to combat counterfeit drugs.

Russia

Counterfeit drugs have become a growing problem in the Russian Federation in the past decade. In 2006, the Federal Service for Health Sphere Supervision (FSHSS) reported that ten percent of all drugs on the Russian market were counterfeit, but other estimates have shown that these rates have climbed up to twenty per cent. In addition, the Russia mafia is also known to be involved in the trafficking of counterfeit drugs. Russia, along with other ex-soviet countries, are experiencing worsening effects related to the trade each year, and these are a clear indication that stronger, stricter enforcements must be enforced.

Asia

It is generally acknowledged that the biggest sources of counterfeit drugs are Asian countries, the largest sources being India and China. These countries are not only the biggest source of production, but are also the origin of many counterfeit shipments. Counterfeiters in Asian countries are extremely skilled, and are often able to conduct their trade with almost no difficulty. Despite relatively strict regulations regarding counterfeiting in China, there seems to be no wavering in counterfeit production levels, with similar situations in other neighboring countries. Most of these countries are aware of their current situations and are in favour of preventing further growth of the counterfeit drugs industry.

North America

Although the severity of the issue is of a much smaller scale in North America than that of less developed countries, North American countries are also victims of counterfeit medicines. Following the numerous cases of counterfeit Viagra that blew up in several media outlets, particularly the interception of a large shipment at Miami in 2010, there have been multiple cases of fake and substandard medicines causing health problems and even death. However, because of the relatively strict laws that are enforced in these countries, the trafficking of counterfeit drugs is generally restricted. Interestingly enough, pharmaceuticals in the United States, many which are prone to cover up fraudulency in the industry, have collectively spent over $1.5 billion to lobby the federal government in a ten-year span. Nonetheless, North American countries are probably open to cooperating with other countries in projects and operations.

European Union

The countries of the European Union have generally been active in their preventive efforts. There are several European health organizations that have contributed to countering falsified medicines. These countries have a very low proportion of counterfeit drugs, not exceeding one per cent of the
However, there is evidence of the involvement of European criminal organizations in counterfeit operations has been uncovered. The countries in the European Union are determined to halt counterfeit operations, and are also likely to contribute to international preventative efforts.

Discussion Questions

1. In ways do advancements in technology change the situation in the trafficking of counterfeit drugs?
2. What is the best way to address the situation of high priced medicines in rural areas?
3. What are some ways to identify between counterfeit and legitimate drugs?
4. How can the UNODC monitor clandestine movements of the underground trade?
5. In what ways does an internationally accepted definition benefit member states? Do definitions specific to each member state benefit or merely cause unnecessary confusion?
6. Are international pharmaceutical product control policies necessary? Or should each individual state determine its own standards?
7. Why has the issue of counterfeit medicine been underreported in the past years?

Additional Resources

UNICRI – Counterfeit Medicines and Organised Crime

Counterfeit Drugs and National Security

WHO – General information on counterfeit medicines

UNODC – Counterfeit focus sheet
http://www.unodc.org/documents/counterfeit/FocusSheet/Counterfeit_focussheet_EN_HIRES.pdf

Article on illegal medicines

Bibliography


