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"CONTEMPLATING DIPLOMATIC FRACTURES WHILE BREAKING THE CYCLE OF SOCIOPOLITICAL INJUSTICE AND APATHY''

Addressing Persistent Inequities in Access to Medical Resources Rooted in Historical Emperyalism

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Committee: World Trade Organization

Issue: Addressing Long-Standing Inequalities in Medical Resource Access Stemming from Historical Imperialism

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Introduction

Global access to medical resources remains deeply unequal, especially in regions affected by historical imperialism. Colonial powers often weakened local health systems and created economic dependencies that still shape healthcare access today. These inequalities now appear in limited vaccine availability, unequal distribution of essential medicines, and barriers created by global supply chains and intellectual property rules.

This agenda aims to recognize these historical roots and encourage the international community to work toward fair, sustainable, and long-term solutions that strengthen healthcare systems and ensure equal access for all nations

Definition of Key Terms

Imperialism: The policy of extending a country's power by taking control of other regions, often through political, economic, or military domination.

Colonial Exploitation: The extraction of resources, labor, and wealth from colonized territories by colonial powers, usually benefiting the colonizer and harming the local population.

Post-Colonial Inequality: The long-lasting economic and social inequalities that remained after colonies gained independence, caused by decades of exploitation and uneven development.

Structural Injustice: Deep-rooted systems or institutions that consistently disadvantage certain groups or nations, often due to historical policies like colonialism.

Legacy of Colonialism:Long-lasting problems from colonial rule that still affect formerly colonized countries today.

Decolonization: The process through which colonies gained independence from imperial powers, often involving political struggle, negotiation, or conflict.

Global North / Global South Divide: A socio-economic divide where wealthier, more industrialized countries (Global North) have more power and resources than poorer, historically colonized countries (Global South).

Neo-Colonialism: Modern forms of control where powerful countries or corporations influence and dominate weaker nations economically or politically, even without direct colonization.

General Overview

The long-term consequences of colonial medical structures become even clearer when examining the way imperial powers defined who deserved care, who merited protection, and whose suffering was considered unimportant within the broader vision of empire. In many colonial regions, medical systems were explicitly racialized: European settlers, administrators, and soldiers received modern hospitals, sanitation systems, and preventive healthcare, while indigenous populations were forced to rely on overcrowded, underfunded, and poorly equipped facilities. These patterns were justified through pseudoscientific racial theories that portrayed colonized populations as biologically inferior, naturally disease-ridden, or inherently unhygienic, thereby absolving colonial authorities of responsibility for poor health outcomes. Such narratives were not harmless; they shaped policy, influenced budgets, and rationalized neglect. When outbreaks occurred, the blame was placed on cultural practices, lifestyle, or supposed backwardness, rather than on structural failures created by colonial governance. These racist assumptions were embedded deeply into the administrative machinery of imperialism, and they influenced decisions on funding allocation, infrastructure development, and the prioritization of medical research. Consequently, entire regions experienced decades—or even centuries—of internalized disadvantage, which continued long after independence as governments struggled to rebuild health systems that had never been designed for universality or equity.

One of the most significant yet often overlooked consequences of this colonial legacy is the distortion of epidemiological landscapes in formerly colonized societies. Many diseases that became endemic in the Global South, such as cholera, malaria, tuberculosis, yellow fever, and sleeping sickness, spread not because of indigenous behaviors but because of environmental transformations introduced by colonial economic activities. Forced labor systems, plantation agriculture, mining operations, and the construction of export-oriented infrastructure created ideal conditions for the spread of disease. For example, the alteration of natural waterways to support cash-crop cultivation increased mosquito breeding sites, causing malaria rates to rise dramatically in regions where it had previously been less severe. Railway construction brought laborers into crowded camps with poor sanitation, accelerating the transmission of tuberculosis and cholera. Colonial cities often featured segregated

neighborhoods where indigenous populations lived in overcrowded and poorly ventilated housing near industrial centers, while Europeans resided in spacious, sanitized districts with access to clean water. As a result, health disparities were not merely social but spatial; disease patterns became mapped onto racial divisions. Even after independence, these patterns persisted because the built environment—housing layouts, sanitation systems, transportation routes—continued to reflect the inequalities created during colonial rule. Many postcolonial governments inherited cities and rural infrastructures that were fundamentally incompatible with equitable health management.

Another major dimension of this issue involves the way colonialism shaped global medical knowledge and scientific authority. During the height of European imperial expansion, colonial territories became laboratories for Western scientists who conducted medical experiments, clinical trials, and research—often without consent from local populations. These experiments contributed significantly to the development of Western medicine, yet they rarely benefited the communities subjected to them. Research conducted in colonies enriched universities and scientific institutions in Europe while providing little or no long-term health infrastructure to the regions where the studies took place. This dynamic created a global imbalance in scientific authority that still exists today. Medical expertise is disproportionately concentrated in the Global North, where the majority of world-leading universities, pharmaceutical companies, and research institutes are located. This imbalance means that diseases affecting wealthy populations, such as heart disease, certain cancers, and neurological disorders, receive far more funding and research attention than illnesses primarily affecting the Global South. As a result, conditions like dengue fever, Chagas disease, schistosomiasis, leishmaniasis, and other neglected tropical diseases remain understudied and underfunded, leaving millions of people without effective treatments.

Moreover, the pharmaceutical industry remains deeply shaped by colonial and post-colonial power structures. Many former colonies still lack domestic manufacturing capacity and rely heavily on imports or international donations for essential medications. This dependency became particularly evident during the HIV/AIDS crisis, when antiretroviral drugs—initially priced at levels far beyond the budgets of African and Asian governments—remained unavailable to millions of infected individuals. Pharmaceutical companies defended high prices through intellectual property laws that were originally developed by imperial powers and later integrated into global trade agreements. These laws prevented local production of generic medications even in countries facing catastrophic public health emergencies. It was only after extensive political activism, legal challenges, and global pressure that certain countries were allowed to manufacture generics for emergency use. Even today, however, the ability of lower-income nations to produce or access essential medicines remains constrained by international intellectual property frameworks that reflect the priorities of wealthy states rather than global health equity.

To understand the persistence of these inequities, it is also essential to examine the role of global governance institutions that emerged during and after the colonial era. Whether intentionally or not, many of these institutions reproduced power imbalances in their

decision-making structures. For instance, organizations responsible for global health, trade, and development often allocate leadership positions, voting influence, and agenda-setting authority in ways that favor wealthier countries. This means that policies affecting the Global South—such as vaccine distribution, trade regulations, and funding decisions—are frequently shaped by actors who may not fully understand, prioritize, or represent the needs of developing nations. The dominance of high-income countries in these systems perpetuates patterns in which wealthy states control the flow of medical resources, decide which diseases are globally important, and influence the direction of scientific innovation.

Another crucial layer is the economic dependence built into postcolonial health systems. Many former colonies entered independence with minimal financial resources, weak administrative structures, and little industrial development. This made it difficult to build robust healthcare systems capable of addressing the needs of their populations. To compensate, many governments relied on international aid, loans, and development assistance. Although well-intentioned in some cases, these financial structures often reinforced dependency by tying aid to specific conditions, limiting policy autonomy, or prioritizing donor-driven projects rather than long-term national strategies. Structural adjustment programs in the late 20th century further undermined health systems in many countries by imposing austerity measures that cut public spending on healthcare, education, and social services. These policies, influenced by institutions dominated by former colonial powers, significantly weakened health infrastructures at the very moment when countries were facing rising burdens of infectious and chronic diseases.

An additional dimension concerns the sociocultural impacts of colonial medical practices, which created barriers to trust and cooperation between communities and health authorities. In many colonial territories, public health campaigns were implemented without community consultation, often relying on force, intimidation, or punitive measures. Vaccination campaigns sometimes involved coercion, with individuals being vaccinated against their will or without proper explanation. Quarantine measures separated families, restricted movement, and disrupted livelihoods. Such actions were not merely administrative failures; they constituted violations of human rights and dignity. As a result, many communities developed deep mistrust toward government-led health interventions, associating them with oppression rather than protection. This mistrust has survived into the present day in various forms. Vaccine hesitancy, fear of hospitals, suspicion toward foreign medical workers, and resistance to public health campaigns can often be traced back to memories—whether lived or inherited—of colonial-era abuses. This legacy complicates modern health initiatives, especially during emergencies when rapid cooperation is essential. Governments attempting to control outbreaks must work against a historical backdrop in which medical authority is associated not with safety but with coercion.

Expanding further, it is important to examine how imperialism influenced nutrition systems, food security, and the biological resilience of populations. Colonial agricultural policies prioritized cash crops such as cotton, rubber, tea, sugar, and tobacco over subsistence farming. This shift forced many communities into monoculture economies that were more

vulnerable to famine, poverty, and malnutrition. Dietary patterns were reshaped by colonial trade demands, often reducing access to diverse and nutritious foods. Malnutrition weakened immune systems and increased susceptibility to infectious diseases, particularly among children and pregnant women. These vulnerabilities persisted across generations, creating cycles of poor health that were extremely difficult to break. Today, many postcolonial states face double burdens: high rates of malnutrition alongside rising levels of obesity and chronic disease, both linked to globalized food markets shaped by historical economic structures. Thus, medical inequity extends beyond hospitals and vaccines—it includes the very foundations of physical survival shaped over centuries.

The environmental consequences of colonial exploitation also continue to influence health disparities. Deforestation, mining, forced migration, and land dispossession altered ecosystems in ways that increased human exposure to disease vectors. Regions once rich in biodiversity were transformed into industrial landscapes where zoonotic diseases—those transmitted from animals to humans—could more easily emerge. Contemporary outbreaks of diseases such as Ebola illustrate how ecological disruptions linked to historical exploitation interact with modern vulnerabilities. Climate change further intensifies these risks, disproportionately affecting countries with fewer resources to adapt—many of which were former colonies that contributed little to global emissions yet bear the heaviest burdens. Rising temperatures expand mosquito habitats, increase the spread of malaria and dengue, and threaten water supplies. These environmental stressors combine with weak healthcare systems to create conditions in which preventable diseases become deadly.

In addition to historical case studies such as the Bombay Plague, other colonial-era health crises reveal similar patterns. For example, during the 1904–1908 sleeping sickness epidemic in East Africa, German and British colonial policies relied heavily on forced relocations, internment camps, and punitive controls. Indigenous practices and healing methods were dismissed as unscientific, yet colonial interventions often worsened the crisis by disrupting community structures and livelihoods. In French West Africa, colonial authorities used mass vaccination and forced labor to extract cotton, imposing harsh medical regimes that ignored local cultural norms. During the Belgian occupation of the Congo, medical facilities existed primarily to maintain the productivity of forced laborers rather than to protect the Congolese population. In North Africa, the French used hospitals not only as health institutions but as instruments of social control, dividing Algerian society and undermining local authority. These patterns were repeated across dozens of territories, establishing a consistent template: colonial medicine was rarely designed to promote equity, and its legacy continues to shape the capacity of nations to protect their populations.

It is also vital to consider the psychological and educational impacts of imperial health structures. Colonial education systems often portrayed Western medicine as superior while devaluing indigenous healing traditions, which were labeled as superstition or witchcraft. This delegitimization weakened traditional knowledge systems that had sustained communities for centuries. At the same time, colonial governments actively restricted access to higher education, including medical training. Very few colonized individuals were allowed

to become doctors, pharmacists, or researchers, and those who did usually faced limited opportunities for advancement. This deliberate exclusion created a deficit of skilled professionals that endured long after independence. Postcolonial governments have had to rebuild medical education from scratch, a process that requires decades of investment. The shortage of medical personnel in many countries today cannot be understood without recognizing the historical context in which generations of potential doctors were denied education by colonial policy.

Traditional medicine, despite its delegitimization, remains an important component of healthcare in many societies. In some regions, traditional healers are the first—and sometimes only—source of care for large segments of the population. However, the relationship between traditional and modern medicine is often strained, not because of inherent incompatibility but because of the colonial legacy that positioned Western medicine as the only legitimate form of healing. Efforts to integrate traditional medicine into national health systems have faced challenges related to regulation, funding, research, and public perception. Nevertheless, understanding this tension is essential for designing inclusive health policies that respect cultural diversity while ensuring safety and efficacy.

Finally, addressing these inequities requires more than investment or reform; it requires a fundamental rethinking of global health ethics. It involves recognizing that the inequitable distribution of medical resources is not an accident of history but a predictable outcome of structures designed to prioritize the interests of a few over the needs of many. Global health justice demands not only the redistribution of resources but the restructuring of power. It requires acknowledging historical responsibility, dismantling unfair intellectual property regimes, supporting technological transfer, expanding local manufacturing capacity, enhancing community-based health governance, and ensuring that formerly colonized states have equal voices in global decision-making. Only by confronting the full depth of historical injustice can the world move toward a future in which access to healthcare is not determined by the legacies of empire.

Major Parties Involved

World Health Organization (WHO)

The World Health Organization is the principal international body responsible for global public health coordination. Established in 1948, WHO works to improve health systems, support vaccine distribution, and provide technical guidance to member states. However, WHO's role is deeply intertwined with inequalities rooted in historical imperialism. During the decolonization era, WHO's strategies often favored countries with existing infrastructure—primarily wealthier states—due to resource limitations and political pressure from major funding contributors. WHO has been criticized for unequal distribution during major crises, such as the 2009 H1N1 pandemic and the 2021 COVID-19 vaccine rollout, where high-income countries acquired most early supplies. The organization also launched

COVAX, aiming to provide equitable vaccine access, yet faced severe criticism because wealthy donor countries bypassed the mechanism through bilateral deals, reducing availability for lower-income, formerly colonized regions. WHO continues to play a key role in addressing structural inequities but struggles against political pressures from powerful states.

United Nations Children's Fund (UNICEF)

UNICEF is a UN agency that supports children's rights, development, and health, particularly in vulnerable and low-income regions. Since its founding in 1946, UNICEF has taken on significant responsibilities in immunization campaigns, nutrition programs, and maternal health initiatives across Africa, Asia, and Latin America—all regions heavily affected by colonial medical neglect. UNICEF's Expanded Programme on Immunization (EPI), launched in 1974, became one of the largest medical interventions in post-colonial states; however, the program faced criticism for insufficient infrastructure investment and reliance on donor funding rather than sustainable national systems. UNICEF has also been involved in controversies related to vaccine supply prioritization, especially when life-saving vaccines were delayed in certain regions due to market shortages or political decisions made by wealthier partner states. Despite these challenges, UNICEF remains one of the largest providers of medical resources in underdeveloped areas.

Médecins Sans Frontières (Doctors Without Borders – MSF)

MSF is an international medical humanitarian organization founded in 1971, primarily working in conflict zones, areas affected by epidemics, and regions lacking medical infrastructure. MSF is highly relevant to the agenda because it often operates in countries whose health systems are weak due to centuries of colonial neglect. The organization has repeatedly criticized global patent laws, pharmaceutical monopolies, and unequal pricing systems that prevent low-income countries from accessing essential medicines. MSF played a crucial role in exposing the high prices of HIV/AIDS medications in the 1990s and early 2000s and actively challenged pharmaceutical companies and Western governments for blocking generic drug production. The organization continues to advocate for decolonizing global health systems, fairer medical supply chains, and increased local manufacturing capacity.

The African Union (AU)

The African Union, established in 2002 as the successor of the Organization of African Unity (OAU), is a central actor in addressing health inequalities across Africa, a continent heavily

shaped by colonial medical exploitation. The AU's Africa Centres for Disease Control and Prevention (Africa CDC), launched in 2017, emerged as a continental response to the systemic inequities caused by historical imperialism. The AU has openly criticized unequal vaccine distribution, particularly during the COVID-19 pandemic when African countries received vaccines months later than the Global North. The AU has been lobbying for the TRIPS waiver—an effort to temporarily suspend intellectual property protections for vaccines—to allow African nations to produce their own medical technologies. It has also emphasized the importance of breaking dependency on former colonial powers and expanding regional pharmaceutical production.

The European Union (EU)

The European Union is directly tied to the legacy of historical imperialism because many of its member states were once colonial powers that shaped modern global health inequities. Countries such as the United Kingdom, France, Belgium, Germany, Portugal, and the Netherlands controlled territories where healthcare systems were underdeveloped, segregated, or used to support economic extraction rather than public welfare. In modern times, the EU is a major actor in global health funding, vaccine research, and development aid. However, the EU has faced controversy for "vaccine nationalism" during the COVID-19 pandemic, blocking exports of vaccines while securing large stockpiles for itself. Additionally, EU pharmaceutical regulations and patent protections have been criticized for restricting access to affordable medications in the Global South. The EU continues to balance support for global health with national interests influenced by its historical legacy.

United Kingdom

As one of the world's largest former colonial empires, the United Kingdom played a major role in shaping global health inequalities. In colonies such as India, Nigeria, Kenya, and South Africa, the British constructed healthcare systems primarily to protect colonial administrators and labor forces rather than local populations. The aftermath of the 1896–1897 Bombay Plague, forced medical inspections, racial segregation in hospitals, and coercive sanitation laws all contributed to long-term distrust of public health institutions. Today, the UK remains a major global health actor through agencies like the Foreign, Commonwealth & Development Office (FCDO) and the Wellcome Trust. However, its influence in pharmaceutical markets and intellectual property negotiations, particularly within the WTO, has sometimes reinforced inequalities rooted in its imperial history.

France

France's colonial empire in North and West Africa significantly shaped the region's public health landscape. Colonial policies in Algeria, Senegal, Mali, Madagascar, and other territories prioritized French settlers and military personnel. Hospitals were segregated, and indigenous populations were often subjected to forced vaccination campaigns and medical experimentation. France's influence persists today through the Organisation Internationale de la Francophonie and continued economic partnerships with former colonies. In recent years, France has been criticized for maintaining unequal medical relationships with African states, especially regarding access to French-produced pharmaceuticals and medical research partnerships that disproportionately benefit French institutions. Nonetheless, France is also one of the largest contributors to global health initiatives such as Gavi and the Global Fund.

India

India plays a crucial role as both a formerly colonized state and a major modern pharmaceutical producer. Under British colonial rule, Indian healthcare infrastructure was extremely limited, underfunded, and primarily designed to protect European populations. Events such as the Bombay Plague of 1896–1897 highlight the coercive and discriminatory nature of colonial medical policies. In modern times, India has become known as the "pharmacy of the Global South," producing affordable generic drugs for HIV, tuberculosis, and other diseases. India's legal battles against multinational pharmaceutical companies—particularly regarding intellectual property rights—have been central to global discussions on medical equity. The country has also led the push for the TRIPS waiver to expand vaccine production in lower-income nations.

People's Republic of China

China is a significant modern actor due to its role in providing medical aid, building hospitals, and supplying pharmaceuticals to African and Asian countries. Although not a former colonial power on the same scale as European empires, China's growing influence has led to debates regarding "medical neo-colonialism." Some argue that China's Belt and Road Initiative (BRI) strengthens healthcare systems in developing regions, while others criticize loan conditions, quality of medical supplies, and political motives behind Chinese health diplomacy. China's vaccine diplomacy during COVID-19, particularly through Sinopharm and Sinovac donations, demonstrated its increasing role in shaping global access to medical resources.

Gavi, the Vaccine Alliance

Gavi is a public–private global health partnership founded in 2000 to improve vaccine access for children in low-income countries. Gavi has played a major role in reducing vaccine-preventable diseases but faces criticism for heavily relying on pharmaceutical companies and private donors, which can reinforce unequal global power structures. During the COVID-19 pandemic, Gavi co-led the COVAX initiative, intended to ensure equitable vaccine distribution. However, COVAX struggled due to wealthy countries purchasing the majority of early vaccine supply, exposing the systemic weaknesses of global medical distribution.

Timeline of Key Events

1857–1947: British Colonial Rule in India	Britain controls India, shaping systems that later result in unequal healthcare, poor sanitation, and limited medical access for local populations
1896–1897: Bombay Plague and Unequal Medical Response	A major plague outbreak hits Bombay. British authorities protect European areas while enforcing harsh measures on Indian neighborhoods, revealing deep colonial inequalities in healthcare
1910–1940: Rise of Western-Led Medical Institutions	Colonial governments and Western organizations build hospitals mostly serving elites and urban centers, leaving rural and colonized populations without proper medical care
1945: Founding of the United Nations	The UN begins promoting global cooperation, including early steps toward international health equity and humanitarian support
1948: Establishment of the World Health Organization (WHO)	WHO is created to coordinate global health. However, structural inequalities rooted in colonial history continue to shape global medical access

1950s–1960s: Decolonization Period	Many countries in Africa, Asia, and the Middle East gain independence, inheriting weak healthcare systems and limited medical infrastructure from colonial rule
1978: Alma-Ata Declaration on Primary Healthcare	Global leaders call for "Health for All," acknowledging that countries need fair and equal access to medical services to develop sustainably
1980s–2000s: Rise of Neo-colonial Health Dependency	Former colonies become reliant on foreign aid, pharmaceutical imports, and externally controlled development programs, reinforcing unequal power dynamics
2020: Global COVID-19 Pandemic	Vaccine access becomes unequal worldwide, with wealthier countries buying most supplies while many lower-income, formerly colonized states face shortages
2021–2023: Global Calls for Vaccine Equity	UN bodies, WHO, and NGOs highlight the need to fix the historical and structural inequalities that caused unequal pandemic outcomes.

Previous Attempts to Resolve the Issue

The international community has taken several steps to address inequalities in access to medical resources, especially in developing and formerly colonized countries. The World Health Organization (WHO), established in 1948, has led global health coordination and disease control efforts, but many states have struggled to implement its programs due to weak healthcare systems inherited from colonial rule.

In 1978, the Alma-Ata Declaration recognized healthcare as a human right and emphasized equal access to primary healthcare. However, limited funding and political challenges reduced its long-term effectiveness. During the 1980s and 1990s, Structural Adjustment

Programs imposed by international financial institutions led to cuts in public healthcare spending in many low-income countries, worsening existing inequalities.

The 2001 Doha Declaration on TRIPS and Public Health aimed to improve access to essential medicines by allowing greater flexibility in patent rules during health emergencies. While it expanded access to some treatments, implementation remained limited. More recently, initiatives such as Gavi, the Global Fund, and COVAX sought to improve vaccine and treatment access, but their impact was constrained by reliance on donor funding and unequal global distribution, especially during the COVID-19 pandemic.

Overall, these efforts have made progress but have not fully resolved the structural inequalities rooted in historical imperialism

Possible Solutions

One possible area of discussion for delegates is the improvement of flexibility within the WTO's intellectual property framework to better respond to global public health needs. Delegates may consider how the TRIPS Agreement can be interpreted or adjusted to ensure that patent protections do not prevent timely and affordable access to essential medicines, vaccines, and medical technologies, especially during public health emergencies. Emphasis may be placed on improving the practicality and accessibility of existing TRIPS flexibilities for developing and least developed countries.

Another potential solution involves promoting greater technology transfer and knowledge sharing through trade-related mechanisms. Delegates may explore ways in which the WTO can encourage cooperation between pharmaceutical companies and manufacturers in developing countries, including voluntary licensing agreements and joint production initiatives. Strengthening domestic and regional production capacity could reduce long-term dependency on imports and increase resilience in global medical supply chains.

Delegates may also examine the role of trade barriers in limiting access to medical resources. Reducing or eliminating tariffs, export restrictions, and non-tariff barriers on essential medical goods, raw materials, and active pharmaceutical ingredients could help improve global availability and affordability. Discussions may focus on ensuring that trade restrictions imposed during health emergencies do not disproportionately affect vulnerable countries.

Supply chain transparency and stability represent another key area for consideration. Delegates may discuss measures to improve coordination among WTO members to prevent shortages of essential medical products during global crises. Enhancing information-sharing mechanisms and encouraging predictable trade flows could support more equitable distribution of medical resources.

Market access and pricing policies are also relevant to WTO discussions. Delegates may consider approaches such as differential pricing, improved access for least developed

countries, and support for fair competition in pharmaceutical markets. These measures could help address long-standing inequalities in access to medical resources rooted in historical imperialism.

Finally, delegates may consider strengthening capacity-building and technical assistance programs within the WTO. Supporting developing countries in understanding and navigating trade rules related to pharmaceuticals and medical products could empower them to participate more effectively in negotiations and protect their public health interests within the global trading system.

Conclusion

Persistent inequities in access to medical resources continue to pose a serious challenge to the international community, particularly for developing and formerly colonized countries. As discussed throughout this report, these inequalities are closely connected to historical imperialism and its long-term effects, including underdeveloped healthcare systems, limited domestic production capacity, and unequal participation in the global trading system. These structural issues remain especially visible during global health emergencies, when access to essential medicines and medical technologies becomes increasingly unequal.

Within this context, the World Trade Organization plays a significant role, as its agreements and regulations directly influence the global trade of pharmaceuticals, medical equipment, and intellectual property. This committee offers a forum for delegates to examine how trade policies can both contribute to and help resolve existing disparities in medical access. During the conference proceedings, delegates are encouraged to engage in constructive and respectful debate on how WTO mechanisms may be improved to better support public health objectives while maintaining a fair and rules-based trading system.

The purpose of this committee is to promote cooperation and mutual understanding among member states in addressing a complex and historically rooted issue. By considering both economic and humanitarian perspectives, delegates are expected to work towards balanced and sustainable solutions. It is hoped that the discussions and outcomes of this conference will contribute to a more inclusive global trading system and encourage collective responsibility in ensuring equitable access to medical resources for all.

Appendix/Appendices

Appendix I: Key WTO Agreements Related to Public Health

This appendix outlines major WTO agreements relevant to access to medical resources, including the TRIPS Agreement and its public health flexibilities. It provides brief descriptions of their objectives and relevance to developing and least developed countries.

Appendix II: Selected Historical Case Study

This appendix provides background information on a historical example illustrating inequities in access to medical resources, such as unequal access to medicines during past health crises in formerly colonized regions. The case study is intended to contextualize the agenda within real-world developments.

Appendix III: Glossary of Key Terms

This appendix includes short definitions of key terms used throughout the report, such as "TRIPS Agreement," "technology transfer," "Global South," and "compulsory licensing," to ensure clarity and consistency during committee discussions.

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