MACMUN 2025

10-Year Anniversary

World Health Assembly

BACKGROUND GUIDE

MACMUN 2025

Staff Letter

Dear Delegates,

It is my privilege to welcome you to the World Health Assembly at this year's Model United Nations Conference. My name is Sumaiya Shariff, and I am honored to serve as one of your committee chairs. I am a Level 4 Honours Justice, Political Philosophy, and Law student at McMaster University, with an academic interest in human rights and global justice, particularly in the realm of international law.

My passion for humanitarian work has significantly shaped my understanding of global issues. As a volunteer with Islamic Relief Canada, I recently completed a mission in Bosnia and Herzegovina, where I contributed to efforts supporting orphans, refugees, and vulnerable communities affected by conflict. This experience allowed me to directly engage with the complexities of humanitarian aid, post-conflict recovery, and sustainable development—key considerations that align closely with the objectives of this assembly.

As delegates, you hold a significant responsibility in addressing the critical issues surrounding global health. I encourage you to approach these discussions with a spirit of collaboration, critical thinking, and a commitment to finding equitable and sustainable solutions. It is through such deliberation that we honor the values and principles of the United Nations.

I look forward to witnessing your dedication and contributions throughout the course of this assembly. Together, we have the opportunity to engage with some of the most pressing challenges of our time and propose meaningful solutions.

Sincerely,

Sumaiya Shariff

MACMUN 2025

Staff Letter

Dear Delegates,

It is with great pleasure that I welcome you to the World Health Assembly committee for this year's MACMUN! We have two exciting topics that I am super passionate about: Non-communicable diseases (NCDs), which we all will be impacted by, and the Opioid crisis, particularly relevant to Canada given the current challenges with tainted drugs and an ever-increasing overdose rate.

I am a fourth year Honours Life Sciences student at McMaster and I will be one of your chairs this year! I have extensive experience in biotechnology with my current focus being my role on the core team of a start-up, AthenaDAO, which has funded over 1.3M women's health research and development and raised much more. I come from a research background, having started with lab-grown insect meat eventually transitioning to poverty intervention, scaling a birth control program in Uganda, so I've been fortunate to see many aspects of the healthcare pipeline.

I've been involved with Model UN since the 10th grade and think it is super fun to get to yap about important topics with super cool delegates. The power to speak and use your voice for change is extremely motivating and I believe MUN does a great job at building confidence and enabling delegates to advocate for the changes they desire to see.

I know you all will do amazing at this year's conference and I can't wait to hear your ideas and perspectives. If you have any questions at all, even outside of MUN as we move closer to the conference, do not hesitate to reach out.

Best of luck and see you soon,

Victoria Dmitruczyk

MACMUN 2025

Staff Letter

Dear Delegates,

It is my pleasure to Welcome you to the World Health Assembly committee this year at MACMUN conference! My name is Vipra Checkera, I am a first year automation engineering student here at Mcmaster University, on a journey to patent law in the future, and I will be one of your chairs.

I began my Model UN journey in grade 11, attending a few conferences independently. Later that year, I founded my school's MUN club, hoping to share my newfound passion with my peers, and continued my journey from there! My agendas in elementary school were always filled with "chatterbox" complaints, which is why I love Model UN and the opportunity it provides to speak on diverse topics you are passionate about.

While I am not in your traditional science fields, during high school I have created two health related ventures, Cactus Kid Health Club, an NFT company which encourages healthy living, and Joey Helps, a mental health company which connects practitioners to young adults, which I am still very passionate about today. Aside from my academics, I grew up a competitive dancer and soccer player back in Toronto. I'm a big FC Barcelona fan, and enjoy watching games with my friends and teammates!

I'm so excited to hear all of your ideas, and watch the committee progress as you work together to find solutions to the two topics. If you have any questions at all, even outside of MUN as we move closer to the conference, do not hesitate to reach out.

Best of luck,

Vipra Checkera

MACMUN 2025

Staff Letter

Dear Delegates,

I am excited to welcome you to this year's Model United Nations Conference and to the World Health Assembly (WHA) committee! My name is Nada Bouchalkha, and I am honoured to serve as one of your committee chairs.

I am a fourth year Honours Political Science student specializing in Public Law and Judicial Studies at McMaster and I will be one of your chairs this year. I was born in Morocco, grew up in the Middle East, and now in Canada- so I really love travelling and have no plans for where I might live in the future! I love painting and recently got back into it over the break, and painted a portrait of my friend as a gift! I also love plants but they never last too long with me to be completely honest. I enjoy reading too, mostly philosophical books like Nietzche and Dostoevsky.

My academic interests are focused on international relations, global policy, and human rights, particularly in the context of public health law. I thoroughly enjoy doing research, with my current project exploring the roles of think tanks in disseminating information, misinformation, and affecting public policy. Through my volunteer work with organizations such as World Vision and Students in Support of the Canadian Red Cross, I was able to learn more about another perspective of law and how much politics can affect all of us in different ways- including in drug misuse and non-communicable diseases.

I am excited to hear your unique ideas and know that your hard work will make this committee a rewarding and impactful experience for all of us! The topics that will be discussed are complex and challenging, but I know that with collaboration and creativity, we'll make this an enjoyable learning experience for everyone involved!

Warm wishes,

Nada Bouchalkha

NON-COMMUNICABLE DISEASES

INTRODUCTION

In an increasingly interconnected world, no nation is immune to the far-reaching consequences of non-communicable diseases (NCDs), nor can any single country tackle this public health crisis in isolation. NCDs, encompassing conditions such as cardiovascular diseases (CVDs), cancer, diabetes, and chronic respiratory diseases, are persistent and universal challenges that transcend borders, age, and socioeconomic status. As the leading causes of death globally, they account for more than 70% of all deaths and represent 9 out of the top 10 reasons for death in developed nations, posing a significant threat to international health and economic stability. The global nature of NCDs necessitates a unified approach, as recognized by the World Health Organization (WHO) and reflected in numerous global health strategies.[17]

Though varying national policies and healthcare infrastructures attempt to tackle NCDs, a collaborative and comprehensive effort is essential to address the root causes, including lifestyle factors like tobacco use, unhealthy diets, physical inactivity, and harmful alcohol consumption. Beyond individual behavior, the burden of NCDs is also deeply influenced by the social determinants of health, including education, income, and access to healthcare. Unlike communicable diseases, NCDs are not caused by infectious agents but result from a complex interplay of genetic, environmental, and behavioral factors. There is an absence of a universal framework for their prevention and management, which may be vital to mitigating the profound impact of NCDs on individuals, families, and economies worldwide.Addressing this urgent health crisis is not only a moral imperative but also a critical step toward achieving sustainable development goals and ensuring a healthier, more equitable future for all.

HISTORY

Despite the earliest records of Non-Communicable Diseases (NCDs) being recognized as early as 3000 BCE, global recognition of NCDs as a major public health concern only gained traction in the mid-1900s, particularly as infectious diseases began to decline in prevalence.[1,2] Previously overshadowed by deadly events such as the 1884 Cholera outbreak that led to the template for vaccination and the Spanish flu, as nations transitioned into industrial and post-industrial economies, priorities shifted to non-communicable diseases.[3,4] In the mid-1900s, leading causes of mortality switched from pneumonia, tuberculosis, diarrhea and enteritis to cardiovascular diseases (CVDs), cancer, and diabetes in industrialized states, though the aforementioned factors were still prevalent in developing regions.[5,6,7]

Shifts in NCDs were primarily driven by urbanization, the invention of mass food production, and the increased usage and accessibility of tobacco.[8,9] The earliest study in the United States, the 1948 Framingham Heart Study, marked one of the first studies to systematically analyze NCDs, particularly identifying high blood pressure, smoking, and cholesterol levels as drivers, highlighting the preventable nature of NCDs.[10, 11] This drove the creation of future anti-tobacco initiatives including the United States Federal Cigarette Labeling and Advertising Act in 1965 (which later expanded to other countries), Norway's tobacco advertising ban in 1975 (with other countries following suit), Japan's 1985 tobacco tax, and Ireland's 2004 nationwide smoking ban in all workplaces (including pubs and bars).[12,13,14,15]

Further investment into NCDs expanded in the late 20th century alongside rising life-expectancy in both high-income and developing regions.[6] Improved healthcare and sanitation reduced mortality from infectious diseases but created a vacuum of chronic conditions.[16] In 1981, the World Health Organization formally identified NCDs as a significant global threat, linking them to economic development and urbanization.[17] In particular, low and middle-income countries (LMICs) suffered from this due to the globalization and adaptation of Western diets and lifestyles, who both bore the burden of infectious and noncommunicable diseases.[16] NCD awareness regarding cancer in the United States accelerated in the 1960s eventually leading to Richard Nixon's 1971 National Act: The War on Cancer, providing $1.6 billion in federal funding and establishing 15 National Cancer Institute-designated cancer centers.[18] The movement expanded beyond the U.S. with the establishment of international organizations like the International Agency for Research on Cancer (IARC), a branch of the World Health Organization (WHO), in 1965.[19] However, cancer globally did not receive as much traction until much later.

The 1990s leveraged awareness around NCDs in the mid-1900s to curb the spread of NCDs. The 1990 Global Burden of Disease Study was the first assessment to comprehensively map the impact of NCDs globally, helping enable tobacco control.[20] In 1999, the WHO's Framework Convention on Tobacco Control was passed, a landmark treaty causing translational changes in the tobacco industry.[21]Despite awareness of NCDs, lifestyle habits contributing to NCDs were rapidly growing, including the increased consumption of processed food and sugary beverages, as well as more sedentary lifestyles.[8]Tobacco consumption primarily shifted to LMICs in this time period as those in the Global North began to shift away from consumption.[22] The increase in aging populations also made NCDs more relevant. In China and India, who had faced predominant growths in population at this time, dementia, cancer, and heart disease surged.[23]

In 2000, the World Health Organization (WHO) formally recognized Non-Communicable Diseases (NCDs) as a major global health priority by adopting the "Global Strategy for the Prevention and Control of Noncommunicable Diseases."[24] This included establishing three primary objectives: surveillance to map the epidemic of NCDs and their determinants; prevention by reducing exposure to risk factors; and healthcare innovation to strengthen health systems for early detection and management of NCDs.[25]Building on this recognition, in 2003, the WHO adopted the Framework Convention on Tobacco Control (FCTC), marking the first legally binding international treaty to reduce tobacco use.[26]

In the following decade, between 2010 and 2019, obesity rates and diabetes surged.[27] However, advancements in medical treatments, screening protocols, and pharmaceutical developments led to reductions in mortality rates associated with NCDs but did not correspondingly decrease the overall disease burden.[28] Disability-adjusted life years (DALYs), which measure the total number of years lost due to ill health, disability, or early death, actually increased during this period, indicating that while fewer individuals were dying from NCDs, more were living with chronic conditions that impaired their quality of life.[29] In LMICs, high costs of medications and limited healthcare infrastructure exacerbated NCDs.[30]

September 2011 marked the United Nations General Assembly on Non-Communicable Diseases, the second instance where a health issue received such attention, following the 2001 summit on HIV/AIDS.[31] This resulted in a political declaration addressing the burden of NCDs, including cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes.[32] They hoped to achieve a 25% reduction in premature mortality from NCDs by 2025, aiming to galvanize international efforts towards prevention, control, and the promotion of healthier lifestyles.[33]

Two years later, the WHO launched the Global Action Plan for the Prevention and Control of Noncommunicable Diseases (NCDs) 2013–2020.[34] Emphasizing a comprehensive approach, the plan advocated for multisectoral collaboration, health system strengthening, and the implementation of cost-effective interventions.[35] Additionally, it highlighted the importance of addressing key risk factors such as tobacco use, unhealthy diets, physical inactivity, and harmful use of alcohol.[36]

In 2015, the UN established their 17 Sustainable Development Goals (SDGs), aiming to target global health, sustainability, and well-being.[37]Addressing NCDs, Target 3.4 aimed to reduce premature mortality from NCDs by one-third through prevention, treatment, and the promotion of mental health and well-being.[38] By integrating NCDs into the SDGs, the international community recognized the necessity of addressing these diseases to achieve sustainable development, emphasizing the importance of comprehensive strategies that encompass health promotion, disease prevention, and equitable access to healthcare services.[39]

BLOC ANALYSIS

Alliance Bloc (High-Income Countries with Advanced Healthcare Systems):

- United States: The U.S. faces high rates of obesity (74% overweight, 40.3% obese) and related NCDs like diabetes and heart disease. Efforts focus on addressing lifestyle factors, improving dietary habits, and expanding preventative healthcare initiatives.[2]
- France: Despite low obesity rates, France experiences significant lifestyle-related NCDs, such as cardiovascular diseases, driven by smoking and alcohol consumption. Public health efforts emphasize prevention and destigmatizing drug use.[3]

- Germany: Germany has a robust healthcare system that prioritizes the management and prevention of NCDs, particularly cardiovascular diseases, through community programs and universal access to healthcare.[25]
- Canada: Indigenous communities in Canada experience disproportionately high rates of cardiovascular disease, highlighting the need for targeted health equity strategies within the broader national NCD framework.[8]
- Switzerland: Switzerland excels in managing NCDs through its universal healthcare system, focusing on early detection, preventative care, and lifestyle interventions.[30]

Neo-Western Bloc (Emerging Economies with Collaborative Ties):

- Japan: Japan's aging population presents challenges, particularly regarding cancer and dementia. Its health system is highly proactive in early detection and care for NCDs.[21]
- Saudi Arabia: Rapid lifestyle changes have led to increasing obesity and diabetes rates, prompting the government to implement initiatives to promote physical activity and healthy eating.[23]
- Mexico: Rising obesity and diabetes have become a national concern, with public health campaigns targeting dietary habits and physical activity to address these issues.[9]
- Colombia: Urbanization has increased NCD risks, and public health policies are evolving to prioritize urban health and preventative measures.[27]

Neutral Bloc (Middle-Income Countries with Limited Global Engagement):

- China: High smoking rates and severe air pollution contribute to widespread NCDs. Efforts focus on air quality improvement and smoking cessation initiatives.[5]
- India: Rapid urbanization has led to a surge in diabetes and cardiovascular diseases. Programs promoting awareness and affordable healthcare access are underway.[17]
- Vietnam and Uganda: These countries face rising NCD burdens due to urbanization, with initiatives beginning to integrate lifestyle changes and public health education.[35,37]
- Indonesia: Lifestyle changes are driving increased NCD prevalence, prompting early efforts to address these trends through awareness campaigns.[9]
- Egypt: High rates of hypertension and diabetes highlight the need for national strategies targeting diet, exercise, and healthcare access.[39]

Critical States (Low-Income Countries with Political and Economic Instability):

- Nigeria: Increasing diabetes and hypertension rates are concerning, but efforts are often overshadowed by resource limitations and the focus on infectious diseases.[13]
- Kenya: The dual burden of infectious diseases and NCDs creates strain on healthcare systems, with efforts often fragmented between the two challenges.[33]
- South Africa: NCDs like diabetes and hypertension are rising alongside an already significant burden of HIV and tuberculosis, necessitating integrated healthcare strategies.[15]
- Brazil: An aging population is driving NCD prevalence, with a growing focus on geriatric healthcare and chronic disease management programs.[11]

Countries in different blocs experience unique challenges and capacities in addressing NCDs. High-income nations lead in preventative and management strategies, while emerging economies focus on adapting public health policies to urbanization and lifestyle changes. Meanwhile, low-income countries face dual burdens of infectious diseases and rising NCDs, often requiring significant international support. There is an evident need for tailored approaches to address NCDs globally, leveraging cross-country collaboration and shared knowledge.

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OPIOID CRISIS

INTRODUCTION

While opioids were, and currently are used as treatment around the world, they are still considered to be dangerous and addictive. They are commonly known to be prescribed for pain management, as well as coughs and diarrhea. The 1990's saw an uproar in opioid abuse and fatalities, beginning the opioid crisis. Opioids account for 80% of drug abuse related deaths around the world, and are one of the leading causes for many cardiovascular and cancer related mortalities. After introduction to codeine, many other drugs such as morphine, heroin, oxycodone, hydrocodone, and fentanyl joined under the opioid umbrella. While countries maintain their own efforts to control opioid abuse and addiction, research and restrictions continue, collaborations between nations for addressing the issue also take place.

There are multiple factors to consider when addressing the opioid abuse issue, and trying to combat it. Considering not only addiction itself, but also illegal smuggling, selling and buying opioids is a major issue in all countries. Many countries are in a collaborative effort with border controls, there are many border restrictions and checks which help to manage bringing illegal opioids across the border, alongside limitations to how much is allowed to cross the border even when it is legal. Treating addiction is fairly similar around the world, the most popular method being methadone or buprenorphine. Opioid abuse continues today as one of the major reasons for mortalities, amid efforts to prevent them from ending up in the hands of the public, alongside addiction from administered opioids. It is imperative that nations work together to manage this issue to ensure that opioids help rather than harm, and ensure good health of the people.

HISTORY

The use and growth of opioids began in 3,400 B.C. Opium poppy was being cultivated in the lower parts of Mesopotamia, found in the southwest of Asia, and was passed on to the Assyrians, who then passed it onto the Egyptians. The effects of opioids became increasingly popular, alongside its demand, where it began to then be grown around the globe for reduced prices. Its cultivation primarily spread from the Mediterranean through Asia to China, also referred to as the Silk Road. It acted as a catalyst here through the Opium wars during the 1800s.[42]

During the civil war in 1861, opium gum and morphine were used medically to treat soldiers, for gunshot wounds, alongside diarrhea and cough. Most patients took the drug orally by swallowing the gum (a minimally processed version of opioid poppy "milk"), while some smoked the opium directly. Many patients also drank Laudanum, a mixture of opium and alcohol, which was also prescribed the same way. Farther into the civil war, doctors began prescribing hypodermic morphine, which slowly became one of the most common forms of taking opiates. Given as painkillers, opium started to become addictive to the soldiers. Opium addiction was severely dangerous to the soldiers health, resulting in overdose and deaths. The addiction to opium became heavily stigmatized in the 1860s, where it was considered unmanly and immoral, resulting in the discussion of punishment towards veterans in place of gratitude and sympathy. The "wonder drug" heroin, also referred to as diacetylmorphine, began preparation as a medicine in the 1870s. In its testing phase, there were many side effects shown in animals (Ie. diminished heart action, fluctuating respiration, dilated pupils) which hindered the interest of the people for the drug. The testing of the drug at this time was for research and chemical purposes, however in 1898 the production of heroin began in Germany, which became widely accepted. The demand for heroin was high due to the high frequency of tuberculosis and other respiratory diseases, alongside its aid in combating the addiction to codeine and morphine.[40,43,46]

Into the 1900s, medical professionals began to realize the negative repercussions and dangers to heroin addiction, as it became readily available, and smuggled around the world to become the main drug of addiction, due to its intense analgesic and euphoric properties, alongside the ease of sniffing it. Pharmaceutical factories started to be seized rapidly as heroin became increasingly addictive in the 1900s. Codeine then acted as a replacement for medicinal purposes, however 6 times the weight was needed to perform on par with heroin. In the Hague Opium Convention of 1912, heroin was placed under the same category as morphine and cocaine. An obligation was imposed to limit the manufacturing, the sale, and use of the drugs for non medical and legitimate purposes. Additionally, preparations exceeding 0.1% of heroin must be controlled, and every country is responsible for determining the way in which they are to do so. Unfortunately, during the World War I outbreak, only 11 countries had actually acted on this obligation, and other conventions were set to deal with the repercussions following the war, however the traffic for illegal heroin travel decreased immensely in the 1940s.[44] In 1931 at the Limitation Conference, a proposal to abolish the use of heroin was rejected, however the UN convened in 1958 with the presence of the WHO, and passed the 1961 UN Single Convention on Narcotic Drugs state, in an effort to reduce the production and use of specific narcotic drugs.[42,44]In the 1990s, after more extensive research, medical prescriptions for opioids increased extensively, and oxycontin was discovered.[45]

The opioid crisis began gaining traction as a public health concern in the early 2000s, rooted in the aggressive promotion of prescription opioids like OxyContin.[47] Pharmaceutical companies, particularly Purdue Pharma, marketed these drugs as effective for chronic pain management, downplaying their addictive potential. The result was a surge in opioid prescriptions, with the United States and Canada becoming the largest consumers of opioids globally during this decade. From 2004 to 2008, visits to the emergency department for nonmedical use of opioids doubled.[48] In 2008, opioid poisoning became a leading cause of death in the United States, with nearly nine out of ten poisoning deaths being related to drugs.[49] Patients who became dependent on prescription opioids often transitioned to illicit substances like heroin due to affordability and accessibility.

This issue particularly affected North America, fueled by the widespread availability of both prescription and illicit opioids. Prescription opioids were recognized as "gateway" drugs to opioid addiction, with individuals transitioning to heroin due to its lower cost and availability.[50] The crisis was driven by a multitude of factors, including overprescription of opioids, the affordability of heroin compared to prescription opioids, and the surge of synthetic opioids like fentanyl entering drug markets. Overdose deaths in the United States involving heroin more than tripled from 2010 to 2014, particularly among individuals aged 25-34, while opioid use disorder (OUD) increased by 150% during the same period.[51] Fentanyl's potency was up to 50 times stronger than heroin and resulted in a significant increase in fatal overdoses.[52] In October 2017, opioid overdoses claimed over 42,000 lives in the US, prompting former President Donald Trump to declare the crisis a public health emergency.[53] Globally, opioid use continued to rise, with England and Wales recording an increase in drug-related poisonings every year since 2012.[54] These trends underscored the multifaceted nature of the crisis, which involved public health systems, pharmaceutical industries, and global drug markets as key actors. In 2019, the opioid crisis led to around 600,000 deaths related to drug use worldwide, with around 25% of these deaths directly caused by opioid overdose.[55]

In Canada, the opioid epidemic claimed nearly 12,800 lives between 2016 and 2019, with British Columbia, Alberta, and Ontario bearing the highest burden.[56] Canada became the second-largest per capita consumer of opioids globally during this time.[57] Reports from British Columbia and Alberta highlighted the disproportionate impact of the crisis on First Nations communities, illustrating the intersection of the opioid crisis with broader issues of systemic inequality and healthcare access.[58] In 2017, seventeen Canadians were reported hospitalized for opioid poisoning each day.[59] By 2018, one in eight Canadians- approximately 4.8 million individuals- received prescriptions for opioids by medical professionals.[60] Amongst these issues, governments across the world took measures to reduce the effects and contributions to the opioid crisis. In 2015, the Canadian Institute for Health Information received 4 years of funding from Health Canada to report and investigate opioid use and its harms across the country.[61] In 2013, Canada recommended guidelines to clinics for safe and lower dosages of opioids to patients facing pain to avoid the risk of OUD.[62] OxyContin was also discontinued in Canada as of 2012 and remained available by prescription in the United States.[63]

BLOC ANALYSIS

Major Powers/Major Consumer Nations

- United States: Had extremely high levels of drug overdose and opioid use. Since 2023, there has been a decline in drug overdose deaths due to the increased availability of naloxone and addiction treatments.
- Canada: Experiencing a severe opioid crisis, with over 70, 000 opioid-related deaths in 2021. The government has implemented measures like safe-injection sites and government-funded drug administration to curb illicit drug use and high overdose rates.
- China: There are increasing overdose rates and the rise in synthetic drugs. The government has announced new regulations on the production of ingredients used to create fentanyl due to pressure from the United States.

Global Supply Chain Bloc (Licit and Illicit)

- Mexico: High levels of illicit drug-trafficking, specifically opioids like fentanyl that are directed to the United States. The government struggles to control the rates of trafficking due to corruption and economic reliance on drug trade income in certain areas.
- India: It supplies over 20% of the world's generic medication. It's unregulated drug production is a significant part of their economy, leading to unregulated opioid use and an increased counterfeit drug production.

- Colombia: Has a growing increase in opioid distribution (10.8 mg per capita), and a growing rate of trafficking linked to overdose patterns.
- Egypt: Increasing drug overdose rates, and almost $2.9 billion spent each year on illicit drugs by almost 800,000 people.

Neutral Bloc (Regulated and Controlled Use Nations)

- France: Government focuses on preventative healthcare such as addiction treatment and stigmatizing drug use through strict regulations. Opioid misuse is not as significant as smoking and alcohol consumption.
- Germany: 1% of the population is on continuous opioid treatment. The government has harm reduction strategies in place for drug users and a strong healthcare system.
- Switzerland: There has been a 177% increase in the rate of calls for poisoning from opioids in 2019. The government has implemented model harm reduction strategies and rehab treatments to address the issue.
- Japan: Maintains low rates of opioid misuse due to strict prescription regulations and cultural norms. The government enforces legislation on drug misuse and regularly monitors opioid distribution. Mental health struggles are prevalent, so the government focuses on this aspect in relation to rising suicides tied to substance abuse.
- Indonesia: Low levels of opioid misuse due to strict drug legislation as the government focuses on drug policy reforms. There remains concern on synthetic opioid trafficking.
- Thailand: 57,000 people used drugs illegally in 2023. Drug laws were strict and punishing but the government has shifted its focus to providing rehabilitation for drug users.

Critical States (Political and Economic Instability Affecting Opioid Overuse)

- Vietnam: An estimated 36 deaths for every million as a result of opioid use. Their death rate is among the highest in East and South Asia.
- Nigeria: Increasing rates of addiction and overdoses due to the misuse of prescription opioids and unregulated medication. The government is attempting to strengthen regulations and provide addiction treatment services.
- South Africa: Substance abuse is prevalent, particularly with codeine medications. Addiction rates are rising and the government is considering enforcing stricter regulations to control access to over-the-counter medication.

- Kenya: An estimated 18,000 individuals use drugs illegally, with 87.5% of drug users using heroin.
- Uganda: Increasing challenges with synthetic drug use like methamphetamine. The healthcare system primarily provides the access to opioids like morphine.
- Brazil: Overdose problems is increasing in urban areas, not as severely as the United States due to strict regulation and legal punishment.
- Saudi Arabia: Opioid abuse started from prescribing medicine for road injuries. Since its introduction, substance abuse issues continue to grow.

Countries across different blocs face distinct challenges in addressing opioid misuse. High-income nations that are major powers are often equipped with strong healthcare systems and are able to provide harm-reduction strategies, though they continue to struggle with rising overdose rates. The global supply chain states are focused on adapting their policies to the growing issues of trafficking and the production of opioids, and struggle with emerging economies. Meanwhile, low-income countries struggle with both rising opioid misuse and other health crises, often requiring international support to strengthen their healthcare systems. These differences highlight the need for targeted, collaborative solutions that consider each country's unique context and capacity.

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