Massachusetts Institute of Technology

Model United Nations Conference

Background Guide

Table of Contents

Letter from the Secretary Generals

Dear Delegates,

It is with great pride and excitement that we formally invite you to the Massachusetts Institute of Technology's 16th annual Model United Nations Conference!

MITMUNC is a premier Model UN conference in which students from all over the world come together to solve the most pressing issues facing society today. This year's conference will be held during the weekend of Friday, February 9th through Sunday, February 11th, 2024, in-person.

At its core, MITMUNC is planned, organized, and directed by a passionate and ambitious team of MIT students that collectively form a diverse family of academic backgrounds and experiences. Our chairs and staff coordinate MITMUNC's committees from the ground up, posing questions and controversies that even the most experienced delegates will find challenging. Our dedicated Secretariat members complement the chairs and staff by overseeing all conference preparations, months in advance of the conference in order to ensure that our delegates walk away with one of the greatest experiences of their lives.

In previous years, MITMUNC delegates grappled with complicated human rights, economic, and environmental topics such as the Syrian Refugee crisis, argued the pros and cons of nuclear energy in the International Atomic Energy Agency, and even reacted to a flurry of assassinations witnessed in the Historical Committee! Attendees also enjoyed inspiring keynote addresses by Nazli Choucri, Professor of Political Science at MIT and leading researcher in international relations and cyber politics, as well as Richard B. Freeman, Faculty co-Director of the Labor and Worklife Program at the Harvard Law School. Delegates also enjoyed a well-deserved respite at the Delegate Dance social night.

We pride ourselves in hosting smaller committee sizes. This allows our attendees more freedom to contribute and distinguish themselves in their individual committee sessions. MITMUNC offers its attendees a truly unique opportunity to immerse themselves in a demanding

intellectual environment, exposed to the ideas of others and tasked to employ the art of negotiation to pass meaningful resolutions.

Having experienced MITMUNC as chairs, then as Secretariat members and Secretaries-General, we are both humbled and thrilled to guide MITMUNC into its best conference yet. I now invite you to explore our brand new website to learn more about our conference. Do not hesitate in contacting us should you encounter any doubts along the way. Best of luck in the path ahead!

Sincerely,

Your Secretary Generals: Jad Abou Ali and Maya Abiram

For further inquiries, do not hesitate to contact us at sg-mitmunc@mit.edu.

MITMUNC XVI 2024

Letter from the Chairs

Dear Delegates,

Welcome to Massachusetts Institute of Technology's 16th Annual Model United Nations Conference! We're very glad to be chairing the World Health Organization committee at MITMUNC. This being a beginner committee, we hope to witness delegates start off their Model UN careers, and develop debate and writing skills within the committee room. Additionally, we're excited to see what points and resolutions you come up with during committee sessions!

Given this is a beginner committee, we understand many delegates will be new to Model UN procedure and structure. Due to this, please do not hesitate to reach out to us with questions and/or concerns. Similar to you, this is the first time chairing MITMUNC for both of us, so if there is any part that you wish to clarify or comment on, please just let us know.

Sincerely,

Your Chair: Isabel Báez Alicea

For further inquiries, do not hesitate to contact us at who-mitmunc@mit.edu.

MITMUNC XVI 2024

Committee Introduction

The World Health Organization (WHO) is a specialized United Nations agency, founded in 1948, reporting to the Economic and Social Council (ECOSOC). The WHO's mission is to "keep the world safe and serve the vulnerable – so everyone, everywhere can attain the highest level of health."[1] The WHO works with all the 194 member states, across 6 regions and more than 150 locations on the ground to support good health and wellbeing of individuals and most vulnerable communities.

In 1945, diplomats met in San Francisco, California, urging to establish an organization that supports the well-being of individuals in countries, especially after failed collaborations between countries to control the spread of deadly diseases across the world. Therefore, the WHO constitution was drafted and submitted in 1946 in the International Health Conference in New York. In 1947, the WHO launched the first-ever global disease tracking service. On April 7th 1948, the WHO constitution came into force. Thus, this date serves as the day of the official launch of the World Health Organization and is now celebrated as the world health day.

Initially, the WHO focused its initiatives on malaria, tuberculosis, yaws, syphilis, smallpox, and leprosy. Later, the WHO expanded to focus on antibiotics, influenza and its mutants, H1N1 detection and treatment, and most recently mental health, newborn health and abortion, HIV treatment, and nutrition plans. WHO showed a significant role in responding to recent crises, such

[1] WHO, https://www.who.int/about

as the COVID-19 pandemic, in which WHO helped vaccine development and provided worldwide support to ensure worldwide access to COVID-19 vaccines and testing to contain the virus. [2]

For the future, the WHO is mainly focusing on three goals, continue working on the planned initiatives for the 2022-2023 budgeting period, capacity building to countries to help reach the triple billion targets, and strengthen accountability and transparency of member states.[3]

[2] WHO, https://www.who.int/campaigns/75-years-of-improving-public-health/milestones#year-2023

[3] WHO, https://www.who.int/about/accountability/budget/programme-budget-digital-platform-2024-2025/executive-summary

Topic A: Worldwide Abortion Inaccessibility and Increased Maternal Death

I. Introduction

In 2020, comprehensive abortion care was deemed by the World Health Organization as an essential health care service. However, to this day, abortion inaccessibility plagues many nations. Currently, 41% of women globally live under restrictive abortion laws. Even in nations with legalized abortion care, factors such as elevated costs, legal guardian consent requirements, prolonged waiting times, and even social stigma negatively impact abortion accessibility.

This inaccessibility results in an increased number of unsafe abortions worldwide. As of 2014, 45% of induced abortions globally were deemed unsafe. Moreover, one third of these abortions occurred under unsafe conditions, utilizing invasive methods and performed by untrained professionals.

A study by *The Lancet* specifies the subcategories of unsafe abortions. “Less safe” abortions, which accounted for 31% of all abortions during 2010-2014, are either performed by a trained professional using a non-safe and/or outdated method, or performed by untrained professionals using “safe” methods. Outdated abortion methods include “sharp curettage”, which consists of the dilation of the cervix and then the removal of uterine tissue with a sharp and/or suction instrument. Safer methods include medications that induce abortions, such as misoprostol. “Least safe” abortions, which made up 14% of all abortions in the same timeline, are performed by untrained professionals using dangerous methods. These methods include introduction of foreign objects into the body and herbal concoctions, and can have a multitude of complications, such as incomplete abortions (failure to remove all of fetal tissue from uterus), hemorrhaging, internal injuries, and infections.

Although many countries provide family planning care as an alternative to official abortion procedures, studies show that abortion inaccessibility does not decrease the number of total abortions, only the proportion of unsafe methods used.

II. History

A. Twentieth World Health Assembly Resolution 1967

Abortion was first recognized as a public health problem during the Twentieth World Health Assembly in Geneva, Switzerland in 1967. The resolution drafted in this conference addressed abortion as a contingent problem within the health aspects of population dynamics, alongside increased maternal mortality rates. They highlighted the need for the development of basic health services within health programs targeted at population dynamics, as well as experienced health service workers. Additionally, they called for the execution of national research projects around the crisis, and the training of university staff and professors.

B. First Unsafe Abortion Mortality Rates Statistics

Although unsafe abortions were recognized in 1967 as a public health crisis, it was not until the Safe Motherhood Conference in Nairobi, Kenya during 1987, that consciousness for the problem began arising. The conference led to the founding of the Safe Motherhood Initiative (SMI), with the goal of targeting increased maternal mortality rates worldwide. However, the initiative did not target unsafe abortion practices initially. In fact, even with the rising urgency of implementing anti-maternal-death strategies, such as obstetric care and family planning services, the World Health Organization hesitated to coordinate calls to action that advocated for accessibility to legal and safe abortion care.

During 1989, the first statistics on unsafe abortions were published by the WHO, under the name “Preventing Maternal Death”. These statistics placed maternal deaths caused by unsafe abortion practices at around 115,000 a year. Later, with the establishment of the organization’s database, countries provided statistics of their own annual unsafe-abortion death toll, and this number was adjusted to 70,000 deaths per year. From this point forward, maternal deaths

associated with unsafe abortions, deemed in 1990 as "abortions not provided through approved facilities and/or persons", made up 13% of all maternal deaths, a number that has remained unchanged to this day.

III. International Actions

A. Movement Towards Abortion Care Availability

In 1995, the World Health Organization issued a set of guidelines set to improve abortion (and abortion-complication care) availability and quality within the primary health care system. Privy to this, however, during the 1994 International Conference on Population and Development, the Programme of Action (POA) reframed the need for abortion care from a "population-control strategy" to an advancement in "reproductive health and rights". This shift in perspective allowed a larger number of countries to reiterate the ongoing health crisis and recognize the need for counteractive measures. In some countries where abortion was still not legalized, this focused on implementing family planning services with the goal of reducing the number of unwanted pregnancies. Countries in which abortion was legal, however, were required to implement some form of abortion care- ensuring these procedures were safe and there were services available to women suffering from abortion complications.

The Worth Health Organization now had a responsibility to provide the specifications for what constituted abortion care, as well as guidelines for proper training of health workers. A multitude of nongovernmental organizations aimed to exercise a woman's right to safe abortions. However, in 1998, WHO director Gro Harlem Brundtland highlighted the need for safe abortions and care to be implemented under governmental health systems, in order to ensure credibility and availability.

B. WHO Abortion Care Managerial Guidelines

The guidelines redacted in 1995, provided clinical recommendations and specified what abortion care services to implement and how to provide them. Not only this, but it also specified

how women could overcome legal and policy barriers that may be blocking their access to such services. The medical recommendations listed in the guidelines were backed up by research on abortion methods, conducted by the WHO-based Special Programme of Research, Development, and Research Training in Human Reproduction since its establishment in 1972.

However, due to extensive review processes by policymakers, program managers, clinical researchers, etc., the final approval for the guidelines was not given until 2003, when they were published under "*Safe Abortion: Technical and Policy Guidance for Health Systems*". The World Health Organization added these guidelines to the "*WHO Strategic Approach to Strengthening Sexual and Reproductive Health Policies and Programmes"*, which, among its many goals, aimed to increase access to family planning services and improve the quality of existing abortion services.

During 2008, the guidelines underwent a review process to include the latest global estimates of unsafe abortions and new methods for service delivery, as well as developments in human rights law and policy that affected service availability. These updates, however, were not approved and published until 2012.

IV. Countries' Positions

Although a variety of countries have adopted liberal policies surrounding abortion, a subsection of nations prohibited it altogether. Given this, the World Health Organization has had to navigate around these policies. Under WHO's provided guidelines in 1995 for abortion care and accessibility, it is stated that "National authorities are responsible for deciding whether and under what circumstances to provide services for the medical termination of pregnancy. *WHO takes no position on the matter*".

As of 2023, abortion care services are available upon request in 75 countries. However, for some of these nations, such as the United States and Australia, these are dependent upon different administrative regions. On another hand, abortion services limited to broad social-economic grounds are available in 13 countries. The resting nations however, limit abortion care to specific conditions; some countries allow abortions to preserve health; others, only allow them if the

childbearer's life is at risk, and some prohibit them altogether. Many countries with these restrictive policies aim to develop family planning services instead, such as increasing access to contraceptives, in order to drive away from unwanted pregnancies that could lead to unsafe abortions. The map below showcases how abortion care accessibility is distributed among countries.

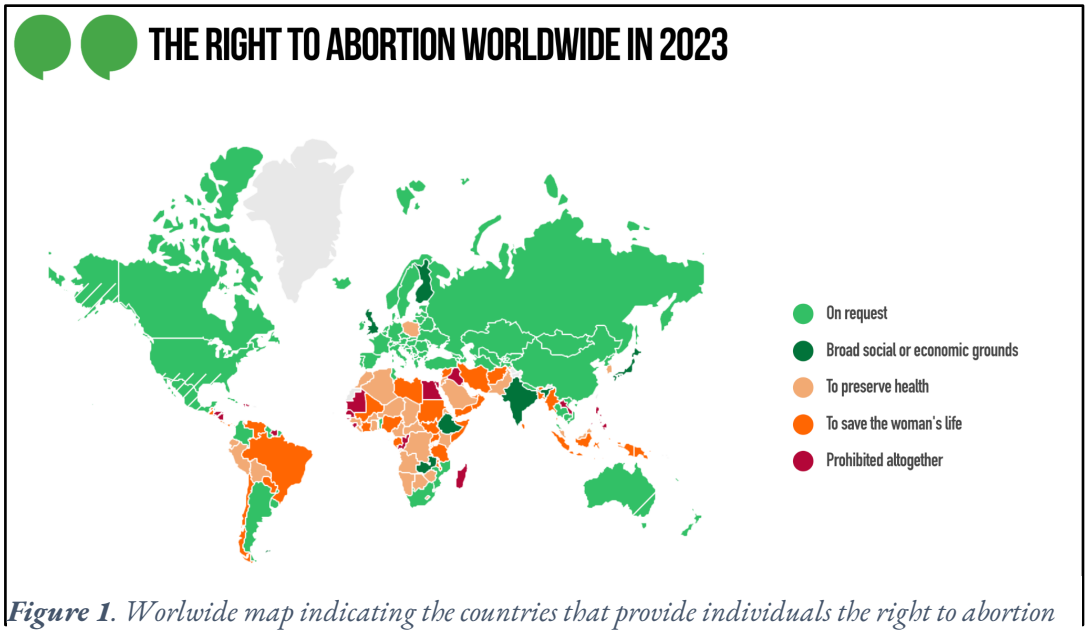

***Figure 1**. Worlwide map indicating the countries that provide individuals the right to abortion in 2023.*

V. Projections and Implications

According to the World Health Organization, 97% of unsafe abortions take place in developing countries. More than half occur in Asia, particularly in the south and central regions. The majority of abortions taking place in regions such as Latin America and Africa are also unsafe, accounting for almost 3 of every 4 abortions performed. In Africa, specifically, nearly half of all abortions occur under the least safe circumstances worldwide.

A. Unsafe Abortions in Sub-Saharan Africa

As of 2019, 92% of women living in the Sub-Saharan region of Africa reside in countries with highly or moderately restrictive abortion laws; these account for 43 countries out of the

48 in the region. Although the proportion of unsafe abortions has remained stable from 2010 to 2019, numbers of abortions have nearly doubled, due to continuous population growth.

Some countries in the region have adopted safer methods, and changed abortion legality legislation. This is in part thanks to the African Union Maputo Protocol, which was signed in 2003, adopted in 2005, and is the only human rights body with explicit language on abortion care. The international organization aims to improve women's autonomy over their bodies and reproductive health, and highlights the necessity of not only legalizing abortion, but also guaranteeing access to safe abortion services. Additionally, apart from the changes in legislation, the popularization of abortion-inducing drugs, such as misoprostol, have made access to safe methods easier.

Regardless, even in countries with laxer legislation, social stigma still maintains the high number of clandestine abortion methods. While the percentage of unsafe abortions worldwide is 45%, in Sub-Saharan Africa it is 77%. Not only this, but the region also has the highest proportion of fatalities from unsafe abortions, at approximately 185 reported deaths per 100,000 abortions.

B. Unsafe Abortions in Latin America and the Caribbean

As of 2017, 97% of women of reproductive age in Latin America and the Caribbean live within countries with restrictive abortion laws, meaning abortion is either completely prohibited or only allowed for medical reasons. Apart from this, proportions of pregnancies ending in abortion have continued increasing, with 60% of them performed under unsafe conditions. In 2014, 10% of all maternal deaths were attributed to unsafe abortion complications.

In recent years, countries have changed their legislation to laxer restrictions around abortion. Argentina, for example, legalized the procedure in 2020, and countries with high populations, such as Mexico and Colombia, decriminalized the procedure. As of 2022, Colombia allows freely available abortions up to 24 weeks into pregnancy. In September 2023, Brazil started a decision-making process to potentially legalize abortion up to 12 weeks

of pregnancy. Nevertheless, countries such as the Dominican Republic and El Salvador still hold complete bans on abortion, with the latter convicting those found guilty with up to 8 years in prison.

The widespread distribution of medications like misoprostol significantly helped increase abortion accessibility in Latin America. Its use as an abortion-inducing drug was first documented during the 1990s in Brazil, and the practice spread throughout the region. Activist groups then adopted these mechanisms and began redacting information and guidelines on how to use the medications safely. In Argentina, they began establishing abortion hotlines to provide information, which then evolved to in-person meetings. This formulated a strategy known as "abortion accompaniment", which aimed to provide support to women across all stages of abortion. These networks expanded worldwide, becoming a prime force in providing abortion care under restrictive legislations.

C. Unsafe Abortions in South and Central Asia

One in four maternal deaths worldwide occurs in the South Asia region. Women in the region have low access to contraceptives, which leads to an increased number of unplanned pregnancies. Apart from this, the majority of countries within the region have restrictive abortion laws, making abortion complications the leading cause for maternal death. This is the case for countries such as Bhutan, which only legalizes abortion to save the life of the woman, if the pregnancy resulted from incest and/or rape, or if the woman is not of sound mental condition. Pakistan has similar restrictive policies, yet it has one of the highest abortion rates worldwide; however, only 68% of these are performed by certified doctors, nurses, or midwives.

Even countries with more liberal legislations around abortion, still significantly limit its access. India's recent abortion laws, for example, allow abortions up to 24 weeks of pregnancy without limitations around marital status. However, the final decision is still up to the doctor, and nearly 10 women die everyday due to abortion complications. Nepal is the only country in the region with freely available abortions upon request. However, the number of providers

and actual practice of these laws remain limited, with only 40% of women in the nation being aware of the legality of abortion methods.

VI. Conclusion

Maternal mortality rates continue increasing due to unsafe abortions. The World Health Organization has a set of managerial abortion care guidelines that recommend appropriate medical procedures and postabortion care, as well as proper training of workers and experienced professionals. However, the WHO has had to navigate through countries' policies and legislations that restrict abortion access, and can only recommend proper abortion care for cases in which the procedure is legal. A lot of these countries with restrictive legislation choose to focus on family planning care, in order to prevent unwanted pregnancies that could lead to termination. However, studies have shown that restricting access to legal abortion procedures does not decrease the number of abortions performed, rather it increases the proportion of unsafe methods used. Nations' policies are not the only thing restricting abortion access: procedure cost, availability, long waiting times, among other factors all play a role. Currently, developing countries face the largest number of increased mortality rates due to unsafe abortion, due both to policy and societal restrictions.

VII. Questions to be Addressed

For this World Health Organization committee, we expect nation representatives to follow their countries' policies on abortion. We want delegates to propose resolutions that directly target unsafe abortions and increased maternal mortality rates, both in their nations and worldwide, while still remaining loyal to their country's legislation. The following are guiding questions to help you prepare for your research.

1. How can international organizations, such as the WHO, navigate abortion care guidance and services in nations with restrictive legislations?
2. What types of family-planning services and contraceptives, as well as their distribution strategies, are most effective in reducing the number of unplanned pregnancies? Will these numbers impact the proportion of abortions performed? If so, how?

3. Should strategies to increase widespread distribution of abortion-inducing medications, such as misoprostol, under restrictive legislations be implemented? If so, how?
4. Some "less safe" abortions are performed by untrained personnel using safe abortion mechanisms. Apart from international guidelines, how can we increase the number of professionals trained in abortion care?

VIII. Bibliography

"Abortion Fact Sheet." *World Health Organization*, World Health Organization, 25 Nov. 2021, www.who.int/news-room/fact-sheets/detail/abortion.

Bankole A et al., From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress, New York: Guttmacher Institute, 2020, https://www.guttmacher.org/report/from-unsafe-to-safe-abortion-in-subsaharan-africa. doi:10.1363/2020.32446

"Fact Sheet: Abortion in Asia." *Guttmacher Institute*, Guttmacher Institute, www.guttmacher.org/sites/default/files/factsheet/ib_aww-asia.pdf. Accessed 17 Dec. 2023.

"Fact Sheet: Abortion in Latin America and the Caribbean." *Guttmacher Institute*, Guttmacher Institute, www.guttmacher.org/sites/default/files/factsheet/ib_aww-latin-america.pdf. Accessed 17 Dec. 2023.

Ganatra, Bela, et al. "Global, regional, and subregional classification of abortions by safety, 2010–14: Estimates from a bayesian hierarchical model." *The Lancet*, vol. 390, no. 10110, 27 Sept. 2017, pp. 2372–2381, https://doi.org/10.1016/s0140-6736(17)31794-4.

Kamdar, Bansari. "Poor Access to Safe Abortions Is Killing South Asian Women." *The Diplomat*, Diplomat Media Inc., 15 June 2021, thediplomat.com/2021/06/poor-access-to-safe-abortions-is-killing-south-asian-women/.

Layton, B. D. B. "THE TWENTIETH WORLD HEALTH ASSEMBLY—MAY 1967." *Canadian Journal of Public Health / Revue Canadienne de Sante'e Publique*, vol. 58, no. 8, 1967, pp.

372–75. *JSTOR*, http://www.jstor.org/stable/41984083. Accessed 11 Dec. 2023.

McReynolds-Pérez, Julia. "Medication Abortion Access Strategies: Lessons from Latin America." *The*
Gender Policy Report, University of Minnesota, 17 Aug. 2022, genderpolicyreport.umn.edu/medication-abortion-access-strategies-lessons-from-latin-america/.

Santora, Emily. "The Impact of the Safe Motherhood Initiative from 1987 to 2000." *Embryo Project*
Encyclopedia, Arizona State University, 2 May 2020, embryo.asu.edu/pages/impact-safe-motherhood-initiative-1987-2000.

Van Look, Paul F A, and Jane Cottingham. "The World Health Organization's Safe Abortion Guidance Document." *American Journal of Public Health* Vol. 103,4 (2013): 593-6. doi:10.2105/AJPH.2012.301204

"Where Do Abortion Rights Stand in the World in 2023?" *Focus 2030*, 16 Mar. 2023, focus2030.org/Where-do-abortion-rights-stand-in-the-world-in-2023#:~:text=The%20vast%20majority%20of%20countries,strictly%20prohibited%20in%2024%20countries.

Zissis, Carin, et al. "Explainer: Abortion Rights in Latin America." *AS/COA: American Society/Council*
of the Americas, AS/COA, 21 Nov. 2023, www.as-coa.org/articles/explainer-abortion-rights-latin-america.

Topic B: Combating the Opioid Overdose Epidemic

I. Introduction

Overdosing has recently been one of the most recent topics for discussion in the WHO, given its serious threat to individuals' lives. Deaths associated with Opioid overdose increased by more than 16% from 2020 to 2021[4], indicating that although there is more awareness across communities, the problem still increasingly persists. Opioids refer to all compounds that are extracted from *Papaver somniferum*, or synthetically made with similar properties that can interact with the brain's opioid receptors. Opioids include morphine, codeine, tramadol, and other substances that are commonly abused.[5]

The World Health Organization (WHO) has an essential role in addressing public health concerns. In collaboration with the United Nations Office on Drugs and Crime (UNODC), the WHO has developed an emergency plan to prevent drug abuse and treat disorders related to that to prevent more deaths related to overdoses.

II. History

A. The Origins of the Opioid Crisis

According to Howard Koh, a professor of the practice public health leadership at the Harvard School of Health, the overdose problem arose from a "multi-system failure"

[4] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, https://www.cdc.gov/opioids/basics/epidemic.html

[5] Opioid Overdose, World Health Organization, https://www.who.int/news-room/fact-sheets/detail/opioid-overdose#:~:text=Worldwide%2C%20about%20600%20000%20deaths,of%20opioid%20overdose%20in%202019.

of the responsible entities to approve the first opioid on the market that led to sudden deaths. [6]

In the mid-1990s, Oxycontin, a powerful legal prescription opioid, has led to a wave of sudden deaths. In 2010, Heroin served as a main source of attraction to already addicted people, leading to a second wave of deaths. In 2013, an unexpected upwards trend was seen in deaths due to the production of synthetic opioids such as tramadol or fentanyl, where the deaths increased from around 3 per 100,000 in 1990 to about 25 per 100,000 in 2021, based on figure 1. [1,2]

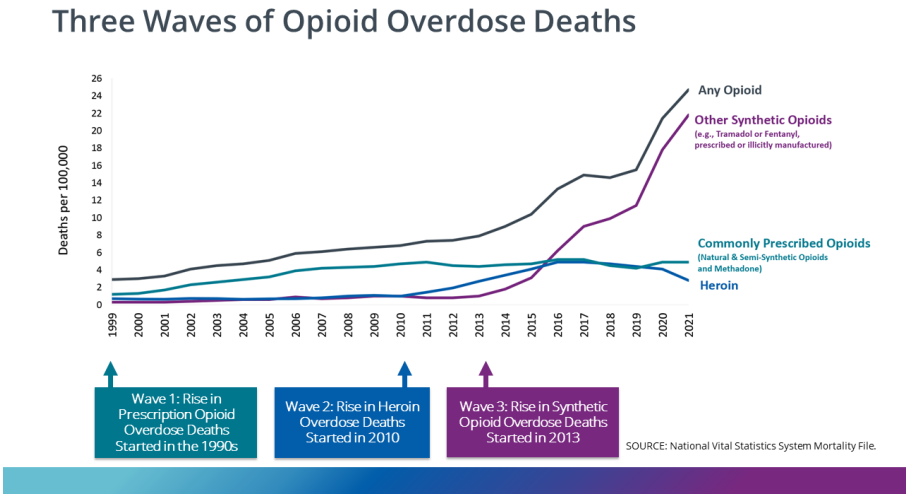

***Figure 2**. Waves of opioid overdose death between 1999 and 2021.*[1]

[6] Harvard School of Public Health, https://www.hsph.harvard.edu/news/features/what-led-to-the-opioid-crisis-and-how-to-fix-it/

B. Effects of Opioid Overdose

The increased availability of opioids on the market, especially in countries where prescriptions are not required to gain access to them, led to an increase in the number of deaths worldwide. Around 70,630 deaths are associated with opioid overdose in 2019 in the United States, with almost half resulting from synthetic opioids. Another factor leading to these trends is the mixing of drugs, associated with illicit drug sale (such as drug dealers), in which fentanyl, a 50-100 times more potent compound than morphine, is being mixed with heroin to increase the potency of the product.[2] As a result, drug users do not realize their fentanyl intake because the counterfeit drugs they are buying assumably have no fentanyl but rather only heroin, for instance.

Opioid overdose risk factors range from taking opioids by injections (or general opioids misuse) to having simultaneous life-threatening disorders such as HIV, and liver or lung diseases. Moreover, alcohol consumption, when combined with opioids increases the risk of overdose, and eventually death. [2]

III. International Actions

A. Combating the Epidemic through an Antidote

Opioid antidotes are one of the most common methods of preventing deaths associated with opioid overdose. Naloxone, an antidote drug, reverses the effects of opioids on humans if taken within the right time frame, the time at which the effects are still reversible. One of the biggest challenges of Naloxone is its lack of availability worldwide. Some countries, such as Canada, Australia, Italy, and Ukraine have made Naloxone available as an over the counter (OTC) medication to enable easy access to overdose prevention methods. Other countries, including the aforementioned ones, have launched efforts in actively distributing Naloxone among communities to improve accessibility. [2]

B. Drug Dependence Treatment and Care

For individuals with long term dependence on Opioid use, Naloxone might not be the most effective method in preventing overdosing. Opioid dependence treatment involves the use of Methadone and Buprenorphine, opioid agonist maintenance treatments, that increase opioid use tolerance, and thus prevent the long-term effects of additional drug misuse. In the 1990s, the early stages of opioid overdose related deaths, France introduced and medically used buprenorphine on affected individuals, which yielded success, dramatically decreasing opioid overdose levels in the country.[7] Since then, such treatment renders successful in limiting overdosing and thus decreasing death rates.

In 2016, and with a collaboration with the UNODC, the WHO launched the Stop Overdose Safely (SOS) initiative to raise awareness on drug dependence treatment and its importance, especially in underprivileged communities.[2] The initiative also provides emergency care in case of an overdose, given the rise in the number of drug abusers around the world. The initiative showed wide success in several countries such as Kazakhstan, Kyrgyzstan, Tajikistan, and Ukraine and was welcomed by almost all stakeholders, including health officials and patients. The SOS initiative is not only limited to drug dependence treatment, though. More than 40000 kits of Naloxone were distributed to communities with limited access to the antidote, which also gave most of the patients threatened with overdose another chance to live.[8]

---

[7] United Nations Office on Drugs and Crime,
https://www.unodc.org/docs/treatment/overdose.pdf

[8] World Health Organization,
https://www.who.int/news-room/factsheets/detail/opioidoverdose

IV. Countries' Positions

A. The United Kingdom of Great Britain and Northern Ireland

Opioid prescribing in the United Kingdom has risen significantly over the past decade due to big pharma in the United States, which includes pharma giants such as Mundipharma.[9] Opiate-related drug poisoning deaths have increased by 388% in England and Wales since 1993. Although the opioid death rate is lower in England than the US, England is still experiencing higher than expected rates of mortality and morbidity from opioids. Opioid-related hospitalizations increased by 49% from 2008 to 2018.[10] The United Kingdom's opiate crisis is mainly from street heroin and synthetic opioids, and priorities lie in hospitalization issues and preventing further effects of US pharma companies.

B. India

While India is not as directly affected by US pharma companies, it is situated between the two largest illicit opium-producing regions of the world – "Golden Crescent" and "Golden Triangle," which makes it vulnerable for being both a destination and transit route for opioids.[11] India has around 4 million opiate users, with a higher concentration of users in northern India, particularly in Punjab. Effective treatment for opiate dependence is either agonist maintenance treatment or opioid substitution therapy, both of which are not easily accessible in India. However, India is a giant exporter of opiates. It is the largest exporter of tramadol to the Middle East/Africa and exports a significant amount of fentanyl to the

[9] https://www.brookings.edu/articles/what-the-us-and-canada-can-learn-from-other-countries-to-combat-the-opioid-crisis/

[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10278447/

[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6201667/#:~:text=%5B2%5D%20India%20has%20twice%20the,opioid%20dependent%20in%20Punjab%20alone

US. India's priorities lie in developing techniques to stop opiate dependence, access to healthcare, and sustaining its economy amidst regulation of drug exportation.

C. Myanmar/Thailand/Laos

The borders where Myanmar, Thailand, and Laos meet form the Golden Triangle, which serve as a major source of opium and heroin production. Myanmar(along with Afghanistan) are the highest producers of heroin in the world, and opium trade is rampant in the Golden Triangle region. A stance against continuing the opiate crisis involves eliminating opium poppy crops that have supported the economies poor and often remote rural communities in Myanmar. The nations in the Golden Triangle must balance elimination of opiate crops along with the re-nourishment of their economies. The communities that are affected look for alternative investments.[12]

D. United States

Rural communities in the US are especially affected by the opiate crisis. The US has committed nearly 1.5 billion dollars to combat the opiate crisis to support states, tribal lands, and territories.[13] The US has focused its efforts on treatment for those who are currently dependent on opiates. However, the US has little regulation for the pharma companies that are exporting the opiate crisis abroad. Many treatments that are approved are not thoroughly regulated, and function as opiates that many misuse as non-medical substances (such as OxyContin). The US must make a change in the healthcare system with

[12] https://www.unodc.org/pdf/research/Golden_triangle_2006.pdf

[13] https://www.whitehouse.gov/briefing-room/statements-releases/2022/09/23/fact-sheet-biden-harris-administration-announces-new-actions-and-funding-to-address-the-overdose-epidemic-and-support-recovery/#:~:text=The%20U.S%20Department%20of%20Health,and%20support%20individuals%20in%20recovery

regards to population pain management if there is to be significant change that mitigates the opiate crisis.

V. Projections and Implications

A. Availability of Opioids

Pain, often called the fifth vital sign, can significantly influence an individual's health status and can have serious negative consequences, including morbidity and mortality. Opioids are an effective treatment for various intractable painful conditions, but problems in global opioid access for safe and rational use in pain management contribute to unnecessary suffering. Opioid abuse affects availability. The United Nations Office on Drugs and Crime (UNODC) reported that an estimated 12-14 million heroin users consumed approximately 375 metric tons of heroin in 2009, yet 5.5 billion people (83% of the world's population) had no access to opioid treatment for pain, based on their Adequacy of Consumption Measure. There is also an unequal distribution of opioids depending on the region. For example, here is the distribution of morphine consumption in various regions in 2005:[14]

[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4052588/

Region	Population, million	Total Morphine Use, kg	Consumption per Capita, mg
North America	331	18,402	55.50
Latin America	549	573	1.04
Western Europe	387	9,296	24.02
Eastern Europe and Central Asia	495	681	1.37
Asia and Pacific	3,620	2,431	0.67
Northern Africa and Middle East	350	103	0.29
Sub-Saharan Africa	741	228	0.30
Global	6,473	31,714	4.90

Reprinted with permission of the International Council on Security and Development.

Figure 2. *Morphine consumption per capita in the different global regions*

B. Monitoring the Illicit Use of Fentanyl

Fentanyl is a potent synthetic opioid that is used as a pain reliever and as an anesthetic. It is approximately 50–100 times more potent than morphine. Fentanyl in various formulations is on the WHO Model List of Essential Medicines. However, fentanyl and its chemically similar analogues (including carfentanil, acetylfentanyl, butyrfentanyl, and furanyl fentanyl) have been associated with a spike in deaths from opioid overdose, which makes monitoring fentanyl an imperative priority(https://www.who.int/news-room/fact-sheets/detail/opioid-overdose). If health interventions continue as they are, the level of fentanyl and its analogues in the illegal drug supply will only increase. Projections suggest that opioid-related deaths may increase through to December 2023, between approximately 1,920 and 2,320 deaths quarterly.[15]

[15] https://www.canada.ca/en/public-health/news/2023/06/modelling-projections-for-opioid-related-deaths-to-december-2023.html

VI. Questions to be Addressed

The following questions must be addressed during the research process in order to ensure a comprehensive and inclusive knowledge of the topic and be able to propose viable and efficient solutions.

1. What suggestions did your country make to address the issue nationally?
2. How is your country willing to support the current initiatives on limiting opioids overdose?
3. How could the past efforts (started in the 1990s up until now) be used as lessons to the resolutions your country is suggesting?
4. To what extent should your resolutions be specifically targeting drug abuse, as opposed to the health implications of doing so?

VII. Bibliography

Ambekar A, Rao R, Agrawal A, Kathiresan P. Research on opioid substitution therapy in India: A brief, narrative review. Indian J Psychiatry.

Canada, P. H. A. of. (2023, June 27). *Modelling projections for opioid-related deaths to December 2023*. Canada.ca. https://www.canada.ca/en/public-health/news/2023/06/modelling-projections-for-opioid-related-deaths-to-december-2023.html

Centers for Disease Control. (2021, June 17). *Understanding the Opioid Overdose Epidemic*. Www.cdc.gov; CDC. https://www.cdc.gov/opioids/basics/epidemic.html

The Federal Register. Federal Register :: Request Access. (n.d.). https://www.federalregister.gov/documents/2023/10/24/2023-23478/special-surveillance-list-of-chemicals-products-materials-and-equipment-used-in-the-manufacture-of

Felbab-Brown, V., Christen Linke Young, A. D., Graham, C., C. Raja Mohan, G. M., Marsin Alshamary, K. H., & Yu, C. (2022, March 9). *What the US and Canada can learn from other countries to combat the opioid crisis*. Brookings. https://www.brookings.edu/articles/what-the-us-and-canada-can-learn-from-other-countries-to-combat-the-opioid-crisis/

Feldscher, K. (2022, February 9). *What led to the opioid crisis—and how to fix it*. Harvard School of Public Health. https://www.hsph.harvard.edu/news/features/what-led-to-the-opioid-crisis-and-how-to-fix-it/

Kazakhstan, U. (2021). *UNODC-WHO Stop-Overdose-Safely (S-O-S) project implementation in*. https://iris.who.int/bitstream/handle/10665/340497/9789240022454-eng.pdf?sequence=1&isAllowed=y

Manjiani D, Paul DB, Kunnumpurath S, Kaye AD, Vadivelu N. Availability and utilization of opioids for pain management: global issues. Ochsner J. 2014 Summer;14(2):208-15. PMID: 24940131; PMCID: PMC4052588.

Roberts AO, Richards GC. Is England facing an opioid epidemic? Br J Pain. 2023 Jun;17(3):320-324. doi: 10.1177/20494637231160684. Epub 2023 Feb 27. PMID: 37342398; PMCID: PMC10278447.

United Nations Office on Drugs and Crime. (2006). https://www.unodc.org/pdf/research/Golden_triangle_2006.pdf

United Nations Office on Drugs and Crime. (2013). *Opioid overdose: preventing and reducing opioid overdose mortality*. https://www.unodc.org/docs/treatment/overdose.pdf

The United States Government. (2022, September 22). *Fact sheet: Biden-Harris Administration announces new actions and funding to address the overdose epidemic and support recovery*. The White House. https://www.whitehouse.gov/briefing-room/statements-releases/2022/09/23/fact-sheet-biden-harris-administration-announces-new-actions-and-funding-to-address-the-overdose-epidemic-and-support-recovery/#:~:text=The%20U.S%20Department%20of%20Health,and%20support%20individuals%20in%20recovery

World Health Organisation. *Opioid overdose*. (2023, August 29). Www.who.int. https://www.who.int/news-room/fact-sheets/detail/opioid-overdose#:~:text=Worldwide%2C%20about%20600%20000%20deaths

World Health Organisation. (2019). *The Public Health Dimension of the World Drug problem: How WHO Works to Prevent Drug misuse, Reduce Harm and Improve Safe Access to Medicine*. Www.who.int. https://www.who.int/publications/i/item/WHO-MVP-EMP-2019.02