

Title: Nuclear Disarmament

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Introduction

Nuclear weapons are the most destructive weapons ever created (1). They have the capacity to instantly destroy entire cities and cause mass casualties. They also threaten immense danger to present and future generations through long-term environmental harm (1).

There are two main approaches to this threat debated by the international community: nuclear disarmament and nuclear deterrence (2). Both approaches seek to ensure that nuclear weapons are never used again. Nuclear disarmament refers to the total elimination of all nuclear weapons worldwide, ensuring there is no possibility of their use (1, 2). The United Nations (UN) has presented this as an urgent global priority and the only way to properly protect humanity from the existential threat of nuclear weapons (1). Nuclear deterrence, on the other hand, relies on states possessing nuclear weapons in order to prevent their use by adversaries, using the threat of mutually assured destruction as a means of discouraging nuclear attack (2).

Nuclear weapons are often framed as a problem of security and geopolitics, but they also constitute a profound global health and humanitarian concern. The International Committee of the Red Cross (ICRC) has emphasised that any nuclear detonation in or near a populated area would constitute an unprecedented global health emergency, with huge levels of mortality and displacement (3). There would be no adequate humanitarian or medical response to the detonation of such a weapon, as it would be far beyond the capacity of any system to manage (3).

Since an effective response to detonation is not possible, the only viable solution to the threat of nuclear weapons is the total prevention of their use. This is then an issue of primary prevention; taking action to prevent health issues before they occur rather than responding after (4). In this context, this means preventing a nuclear detonation from ever occurring again.

SfGH UK's Position

Students for Global Health UK (SfGH) recognises that nuclear weapons present an existential yet entirely preventable threat to global health. Since even a single detonation would completely overwhelm any healthcare system, SfGH maintains that prevention

through disarmament is the only credible long-term health response. Nuclear deterrence is not sufficient to eliminate risk, and only sustains the possibility of catastrophic global harm.

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SfGH further recognises that the harms associated with nuclear weapons are inequitable, arising both from historical testing practices and from age- and sex-based differences in biological vulnerability. Indigenous communities have borne disproportionate health burdens during nuclear testing, and women and children are vulnerable due to inadequate safety regulations in combination with biological differences. Meaningful disarmament must therefore include both the total elimination of all nuclear arsenals and the provision of victim assistance for those who have already been exposed.

SfGH supports strengthened multilateral disarmament efforts, responsible political leadership that reduces nuclear risk, and divestment from the production and modernisation of nuclear weapons. SfGH affirms the responsibility of health students and professionals to advocate for policies that reduce nuclear danger and protect present and future generations.

Calls to Action

Students for Global Health UK to:

- Advocate for nuclear disarmament as a matter of primary prevention through education, campaigning and policy engagement.
- Support research and awareness initiatives highlighting the disproportionate impact of nuclear weapons on indigenous peoples, women and children.
- Collaborate with partners from medical and humanitarian organisations working towards disarmament.

Governments to:

- Fulfil their obligations under Article VI of the Treaty on the Non-Proliferation of Nuclear Weapons (NPT) by engaging in good faith negotiations towards nuclear disarmament.
- Refrain from rhetoric that normalises nuclear threats.
- Engage with the Treaty on the Prohibition of Nuclear Weapons (TPNW), including by signing and ratifying the treaty.
- Provide adequate victim assistance and reparations for communities affected by nuclear testing, to include removing barriers to recognition and compensation for affected individuals.
- In particular, the United States and the Russian Federation urgently pursue a successor agreement to the New Strategic Arms Reduction Treaty (New START) that establishes quantifiable limits on nuclear weapons arsenals.

International Organisations (World Health Organisation (WHO), UN, ICRC etc.) to: ●

- Continue to disseminate evidence on the humanitarian consequences of nuclear weapons.

- Support member states in carrying out victim assistance obligations.

Universities and Higher Education Institutions to:

- Align investment of funds with humanitarian and public health principles.

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- In particular, divest from companies involved in the development, maintenance or modernisation of nuclear weapons.
- Publicly disclose investments and divestment policies to ensure transparency and accountability.
- Support research on nuclear disarmament through the lens of both global health and international law.
- Integrate discussions on nuclear weapons into healthcare-related curricula.

Background

1 Nuclear Weapons as a Health and Humanitarian Threat

Nuclear weapons present an unparalleled threat to global health, and have been described by the World Health Organisation as representing the greatest immediate threat to the health and welfare of humanity (5). This is due to their capacity for rapid mass casualties and long-lasting environmental contamination (6). No other weapon threatens such destructive force and capacity for human suffering (7, 8). As a result, health and medical organisations have consistently argued that prevention is the only viable solution to the risk posed by nuclear weapons. Because the consequences of nuclear detonation cannot be treated or mitigated once they occur, prevention is the only viable public health response (6, 9).

The detonation of a nuclear weapon produces a uniquely compounded pattern of injury through the combination of blast, extreme heat, and ionising radiation (7). Blast waves cause traumatic injuries associated with collapsing buildings and infrastructure, while thermal radiation causes severe burns and can ignite firestorms that consume available oxygen (7). Exposure to high doses of ionising radiation can result in acute radiation syndrome, which can lead to death within days or weeks (7). The combination of these injuries dramatically increases mortality, as radiation exposure compromises the body's ability to recover from trauma and burns that might not otherwise be fatal (7).

Beyond the immediate injuries sustained, nuclear weapons render an effective medical and humanitarian response impossible. There is currently no effective capacity for delivering appropriate humanitarian assistance following the use of nuclear weapons (6, 8). Health systems would collapse due to the destruction of hospitals and transport networks, and large proportions of healthcare workers would be killed or injured (7). Surviving healthcare workers would be unable to safely access affected areas due to radiation and debris (7, 8).

These impacts raise important concerns about deterrence-based approaches to nuclear

weapons. The policy of nuclear deterrence fundamentally relies on the credible threat of inflicting these harms on civilian populations (2). Deterrence only works if every state that possesses nuclear weapons is perceived as willing to use them in response to attack (2). Since its effectiveness relies on this willingness to cause indiscriminate mass destruction, it is fundamentally at odds with public health principles and humanitarian law (2).

The health consequences of nuclear weapons can last for years after detonation and are not confined to national borders. Radioactive fallout can contaminate air, water, and food



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systems far beyond the site of detonation, leading to long-term disease burdens and chronic health impacts (7). Environmental contamination may persist for decades, with potentially catastrophic implications for food security (7).

2 Disproportionate and Inequitable Impacts of Nuclear Weapons

Nuclear weapons do not affect all groups equally. Their development and use disproportionately affects marginalised communities, such as Indigenous peoples, women and children. These inequities are caused by historical colonial testing practices and biological differences in vulnerability to ionising radiation. These disproportionate effects must be taken into account when viewing nuclear disarmament as a matter of health equity.

2.1 Colonial Legacies and Indigenous Dispossession in Nuclear Testing Nuclear-armed states have, throughout the history of atomic testing, selected test sites occupied by indigenous and marginalised peoples (11). These sites are often far removed from the populations responsible for the building and testing of these weapons. The following subsections provide an illustrative though not comprehensive discussion of some of these instances, and the lasting impacts on affected indigenous communities today.

2.1.1 US Nuclear Testing in Western Shoshone Territory

The United States has conducted testing within its own national territory multiple times, including in Western Shoshone territory between 1951 and 1992 (10, 11). Atmospheric tests carried out in 1952 exposed the Indigenous 'Downwinder' communities to radioactive fallout (10). This exposure has been linked to increased rates of cancer, including leukemia and thyroid cancer (11). Radioactive fallout from atmospheric testing at the Nevada Test Site included significant releases of the isotope iodine-131, which concentrates in the thyroid gland and increases the risk of thyroid disease and cancer (12). Despite later compensation schemes, many affected individuals faced prolonged struggles for official recognition of exposure-related illness and access to compensation (10).

2.1.2 British Nuclear Testing in Australia and Its Impact on Aboriginal Communities

Between 1952 and 1963, the United Kingdom conducted nuclear weapons tests in Australia, on land inhabited by Aboriginal communities (11). Indigenous residents in affected areas were neither adequately informed about the testing program nor protected from

radioactive fallout. Authorities failed to consider Aboriginal presence when assessing test risks (13). These tests resulted in widespread environmental contamination and health consequences that have continued to affect Aboriginal communities decades after testing ceased (13).

2.1.3 US Nuclear Testing in the Marshall Islands

Between 1946 and 1958, the United States conducted 67 nuclear weapons tests in the Marshall Islands, resulting in widespread radioactive fallout and the forced displacement of communities (11). Exposure occurred through contaminated land, water, and food supplies. Some populations received almost lethal radiation doses before being evacuated following a 1954 test (11). In some cases, exposed populations were enrolled in radiation studies

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without informed consent, and compensation and long-term healthcare support have remained inadequate (11).

2.2 Gender-Based Biological Vulnerability to Ionising Radiation

Long-term studies of populations exposed to nuclear detonations show that women and girls experience greater biological harm than men when exposed to similar doses of ionising radiation. Women face a higher lifetime risk of radiation-related disease, including increased incidence of solid malignancies and non-cancer outcomes such as cardiovascular disease (14). The susceptibility of certain organs to radiation damage is also higher in women due to differences in physiology and tissue sensitivity (14).

This increased biological risk is further compounded by the derivation of radiation protection standards, which have historically used adult males as reference (14). This results in an underestimation of the extent to which certain doses of radiation will harm women (14).

2.3 Children's and Intergenerational Vulnerability to Radiation

Children are also more biologically vulnerable to the effects of ionising radiation, due to rapid growth, higher cell division rates and developing organs and tissues. Children have been shown to receive proportionally higher radiation doses to certain organs, including the thyroid (15). Early life exposure is associated with increased risk of long-term health effects such as malignancies and developmental disorders (15).

Vulnerability to radiation-induced health issues is greatest where gender and age intersect. Girls who are exposed to radiation in early childhood have been found to have the highest lifetime health risks from radiation exposure (14). The risk posed to girls exceeds that posed to boys at the same developmental stage (14).

There is also evidence to indicate that the health risks associated with radiation exposure may carry beyond the immediately exposed generation (16). Ionising radiation has been found to induce chromosomal and epigenetic changes, and transgenerational effects

have been clearly demonstrated in non-human animals (16). These transgenerational effects, while limited in direct epidemiological evidence, are biologically plausible in humans (16).

2.4 Recognition of Inequity Under International Law

The Treaty on the Prohibition of Nuclear Weapons explicitly acknowledges the disproportionate impact of nuclear weapons on Indigenous peoples, women, and affected communities, and establishes obligations for victim assistance (17, 18). Supporting affected populations and addressing past and ongoing harms is therefore an integral component of nuclear disarmament, alongside the elimination of nuclear arsenals.

3. International Legal Framework and Treaties

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The international legal framework governing nuclear weapons is centred on the NPT, which was adopted in 1968 and is widely regarded as the cornerstone of the global nuclear non-proliferation regime (19, 20, 18).

With 191 States parties, including five nuclear-weapon States (19), the treaty has nearly universal membership. All parties are required by Article VI to engage in good faith negotiations on practical measures pertaining to nuclear disarmament and the end of the nuclear arms race (19, 25, 18). Importantly, though, the treaty makes no mention of deadlines or procedures for confirming this disarmament commitment (18). The lack of progress regarding nuclear disarmament has been a chronic source of tension in the treaty's five-year review cycles (18, 20).

As a result, progress on disarmament has often depended on supplementary arms-control agreements and the political will of nuclear-weapon states to reduce arsenals, though recent geopolitical tensions have further complicated these reductions (20).

In response to the perceived limitations of the NPT and the slow pace of disarmament, the TPNW was adopted in 2017 and entered into force in 2021 (18, 20). The TPNW is the first international treaty to comprehensively prohibit the development, testing, production, stockpiling, transfer, use, and threat of use of nuclear weapons under international law (18). The TPNW does not replace the NPT. Rather, the states that have ratified it view it as an effective measure for nuclear disarmament as required by Article VI of the NPT (18). However, nuclear-armed states and their allies, particularly North Atlantic Treaty Organisation (NATO) members, have largely rejected the treaty, arguing it is incompatible with nuclear deterrence and the NPT's verification standards (18).

Despite this opposition, the World Medical Association (WMA) and other health bodies have welcomed the entry into force of the TPNW, calling on all states to sign and ratify it as a medical necessity (9). Overall, there are strengthening humanitarian norms against nuclear weapons, supported by civil society and non-nuclear states. However, nuclear-armed states still continue to modernise their arsenals and rely on deterrence (21, 9, 18).

4 Recent Changes to the Nuclear Risk Landscape and their Implications for Health The health impacts of nuclear weapons have been well-known since the mid 1940s, and treaties such as the Treaty on the Non-Proliferation of Nuclear Weapons have been in place for decades. However, the political landscape surrounding nuclear weapons has continued to shift in the 80 years since the atomic bombings of Hiroshima and Nagasaki. Recent developments in nuclear governance continue to shape the likelihood of the potential catastrophic harm that further nuclear detonation would cause. From a global health perspective, these changes function as risk determinants that influence the probability of widespread catastrophic health outcomes.

4.1 Expiration of the New Strategic Arms Reduction Treaty

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On the 5th of February 2026, the New Strategic Arms Reduction Treaty (New START) expired, bringing an end to the last remaining bilateral arms control agreement between the United States of America and the Russian Federation (22). These two states combined possess approximately 90% of the world's nuclear weapons (23, 21). New START placed legal limits on the number of deployed nuclear weapons that each state was allowed to possess and, until the COVID-19 pandemic, allowed each state to verify the other's continued participation through regular on-site inspections (22).

Both states remain party to the NPT (24), under which they are required to pursue negotiations in good faith toward nuclear disarmament, according to Article VI (25). The NPT does not, however, place any numerical limit on existing state arsenals. In the absence of a successor agreement to New START, there are currently no bilateral legally binding caps on U.S. and Russian deployed strategic nuclear forces (23). While there is no evidence that either country has yet made any move to expand its nuclear arsenal, the current absence of a formal treaty increases uncertainty and could complicate future arms control efforts (22). A period of weakened arms control agreements increases the long-term probability of nuclear weapon use and the associated public health emergency that would ensue.

4.2 Nuclear Signalling in the Russian Invasion of Ukraine

Since the full-scale Russian invasion of Ukraine at the beginning of 2022, the Russian Federation has repeatedly used its status as a nuclear-weapon state in coercive signalling. The House of Commons Library in the UK has noted that political leadership in Russia has increasingly referenced nuclear weapons in public statements during this time, in addition to changing the state's nuclear doctrine and suspending its participation in arms-control arrangements in an apparent attempt to prevent external military intervention in Ukraine (26).

The US Congressional Research Service has also noted that Russian leadership has invoked nuclear forces as part of a broader signalling strategy described as intended to deter the United States and NATO allies from deeper involvement (27). Although neither report finds evidence of preparations for imminent nuclear use, both emphasise that nuclear threats have become a prominent feature of the conflict, where nuclear weapons were previously not referenced so much in modern wars (26, 27).

This normalisation of nuclear threats during an ongoing conflict highlights the fragility of nuclear deterrence, even without actual nuclear weapon use.

4.3 New Trends in Modernisation of Nuclear Weapons and Technologies Nuclear-armed states continue to modernise their arsenals (28), which in the current context of weakened arms-control frameworks represents a significant development in the risk posed by nuclear weapons. Some of these improvements include capabilities that may lower the threshold for the use of nuclear weapons and have the potential to lead to renewed arms racing (28).

Emerging technologies may also introduce new pathways through which deterrence could fail (2). International assessments warn that faster and more technologically complex systems can reduce warning times and increase the risk of miscalculation during crises (28). Modernisation also raises concerns about the implementation of emerging technologies like

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artificial intelligence into decision-making systems (2, 28, 29). Analysis has highlighted that AI-enabled systems may compress decision-making timelines, introduce automation bias, and reduce transparency and accountability in high-stakes contexts (29). Together, the erosion of arms-control safeguards and the adoption of destabilising technologies increase the probability of nuclear weapon use, whether intentional or not (28, 29).

In summary, nuclear weapons have the capacity to cause catastrophic and inequitable harm to human health. These harms could not be mitigated once they occur. Deterrence, while seeking to manage this threat, cannot completely eliminate the risks that nuclear weapons pose. Disarmament is therefore the only effective form of primary prevention. It is the responsibility of governments, international organisations, healthcare professionals and universities to work collectively to reduce nuclear risk.

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