*Delegates,*

We are pleased to welcome you all to the 2025 Kennesaw State University High School Model United Nations (HSMUN) Conference. My name is Julyana Ayache, and I am honored to serve as your Director of the United Nations General Assembly Plenary 4th. This is my fourth year as part of Kennesaw State University’s HSMUN Conference, and I have three and a half years of experience competing with KSU’s Model UN team. I am a Senior at Kennesaw State University, majoring in International Affairs and minoring in Data Analytics. A fun fact about me is that I was last year’s Secretary-General.

Our committee’s Assistant Director is Lucas Garcia. Lucas is a freshman majoring in information systems. This is his first year participating in KSU’s Model UN and HSMUN, but he has participated in KSU’s HSMUN as a delegate. Some fun facts about him are that he has been to the United Nations headquarters in Geneva, and his favorite Pokémon is Galarian Darmanitan. Our committee’s Chair is Nasier Brown. Nasier, AKA Nas, is a freshman at KSU majoring in Biology but plans to switch to Biochemistry. This is his first year participating in KSU’s MUN and HSMUN. Nas loves researching nations, their history, culture, and languages. He loves food and conversations and is currently an undergraduate researcher.

**The topics under discussion for United Nations General Assembly Plenary 4th Committee:**

1. **Addressing Institutional Inequalities in Healthcare Systems in Occupied Territories**
2. **Establishing Protective Measures for Member States with Nuclear Testing Sites in Occupied Territories.**

Each Member State’s delegation within this committee must submit a position paper presenting their ideas for both agenda topics. A position paper is a short essay describing your Member State’s history and position on the issues. There are three critical parts to any successful position paper: history, current status of the issue, and possible solutions for the future. Information for adequately formatting the position papers and valuable advice for writing a quality paper can be found in the Delegate Preparation section of the HSMUN webpage (http://conference.kennesaw.edu/hsmun/). Delegates are reminded that papers should be no longer than two pages with titles in size 12 and text in size 10-12 Times New Roman. Citations should be footnoted in Chicago-style formatting, such as those used inside this guide.

Furthermore, plagiarism in an academic setting is unacceptable and will nullify any score for the paper. We will use the university’s plagiarism checker during the grading process. Wikipedia is an excellent place to begin researching, but we highly encourage using peer-reviewed academic articles or trusted media sources. A position paper aims to present the diplomatic position of your Member State on both agenda topics as accurately as possible. ***All position papers MUST be sent to ksuhsmun2025@gmail.com by February 21st, 2025. Late papers will be accepted until February 26th, 2025 with points penalized.***

**History of the General Assembly Plenary Fourth Committee: Special Political & Decolonization Committee**

The United Nations (UN) was founded on October 24th, 1945, in San Francisco, California, with an original member count of 51 Member States.The international organization’s primary purpose is to maintain peace and security and uphold human rights in every Member State. Over the years, the UN has worked tirelessly to promote social progress and the development of each person’s standard of living. The United Nations Charter established the six principal organs of the UN. These organs are named as follows: the General Assembly (GA), the Security Council, the Economic and Security Council (ECOSOC), the Trusteeship Council, the International Court of Justice, and the UN Secretariat.

Since the inception of the United Nations, the General Assembly has been the only organ in which all 193 Member States have equal representation and voting power. Every Member State in the General Assembly has one vote under the principle of sovereign equality. Smaller Member States carry the same voting power as larger Member States. Most resolutions in the General Assembly require a simple majority to pass. However, a two-thirds majority is required for critical issues like peace and security, membership, and budget matters. The General Assembly currently consists of six central committees: the First Committee on Disarmament & International Security, the Economic & Financial Committee, the Social Humanitarian & Cultural Committee, the Special Political & Decolonization Committee, the Administrative & Budgetary Committee, and the Legal Committee.

Initially, the Fourth Committee of Special Political and Decolonization Committee was two separate committees in the United Nations. However, in 1993, the two committees combined once the initiatives of the Decolonization Committee were filled and the workload decreased. The Fourth Committee was created to tackle trusteeship and decolonization matters and has expanded to deal with the impact of atomic radiation, an in-depth analysis of peacekeeping operations, special political missions, the United Nations Relief and Works Agency for Palestinian Refugees in the Near East, Israeli policies and settlements, and global collaboration in the peaceful exploration and use of outer space. The following bodies report through the Fourth Committee: Committee on Information, Committee on the Peaceful Uses of Outer Space, Special Committee on Peacekeeping Operations, Special Committee on Decolonization, and Special Committee to Investigate Israeli Practices Affecting the Human Rights of the Palestinian People and other Arabs of the Occupied Territories, the United Nations Relief and Works Agency for the State of Palestine Refugees in the Near East, and the United Nations Scientific Committee on the Effects of Atomic Radiation. The Fourth Committee meets annually in the fall and spring, mainly to adopt resolutions and decisions relating to peacekeeping operations.

The Fourth Committee considers agenda items assigned by the General Assembly Plenary and prepares recommendations and draft resolutions for submission to the General Assembly Plenary. The Fourth Committee considers a range of issues, coordinates peacekeeping missions, reviews information and economic activities that affect the interests of territories under other occupation of Member States, and implements declarations by drafting and recommending resolutions, monitoring progress, supporting special political missions, engaging with key UN bodies, and facilitating global cooperation. The committee’s recommendations focus on the political aspects of an issue. The UN Security Council develops the peacekeeping missions and objectives. At the same time, the Fourth Committee oversees the coordination and operational aspects of the UN peacekeeping missions and the Department of Peacekeeping Operations.

The Fourth Committee currently does not possess the power to enforce laws or policies. However, it functions in the border framework of the UN General Assembly. The Fourth Committee submits draft resolutions and proposals to the General Assembly, and the General Assembly will vote to modify, adopt, or reject them. It plays a significant role in shaping international opinion and influencing the actions of Member States and other UN bodies. It has continuously promoted initiatives targeting the political, economic, humanitarian, social, and legal sectors. The Fourth Committee meetings addressing these sectors have significantly impacted people worldwide.

1. **Addressing Institutional Inequalities in Healthcare Systems in Occupied Territories**

***Introduction***

Institutional inequality refers to disparities embedded in organizations' structures, policies, and practices that result in unequal access to resources, opportunities, and rights for specific groups. Under international law, an occupied territory is a territory placed under the authority of a hostile army[[1]](#footnote-1). In healthcare, occupied territories are usually at a disadvantage. Facilities are underfunded, policies are biased towards specific groups, or access to care is restricted based on ethnicity, religion, nationality, etc. These inequalities are often fixed in society, involving deeply ingrained practices and structural biases reinforcing inequality over time. The Sustainable Development Goals (SDGs) were a set of interconnected global goals designed to achieve a better and more sustainable future for all, and the UN recognizes that discrimination in healthcare settings is a significant barrier to achieving SDG 3: Good Health and Well-Being and SDG 10: Reduced Inequalities. Occupied territories significantly reinforce inequalities in the healthcare system due to neglect and exclusion from occupying forces.

Inequality in healthcare settings, specifically in occupied territories, takes on many forms. Examples include denial of access to services, physical or verbal abuse, involuntary treatment, and the breaching of confidentiality[[2]](#footnote-2) National laws, policies, and practices also perpetuate inequalities in healthcare settings due to prioritization over their populations and neglect in occupied territories. Occupied territories often rely on external actors like non-profit organizations to provide essential resources and access to healthcare. These laws challenge human rights standards. International organizations have difficulty monitoring data in certain regions to establish proper frameworks. Conflict-driven deaths are rising, and poor socio-economic conditions and infrastructural challenges within and between Member States persist. That is often due to inadequate healthcare services or financing, and disaggregated data impedes understanding of addressing those health disparities[[3]](#footnote-3).

 Healthcare crises become more prominent in times of conflict. Due to infrastructure damages, medication shortages, and restricted access, disparities in the healthcare system have become more pronounced. Policies enacted by occupying forces often prioritize their populations, creating structural barriers that hinder the advancement and well-being of local communities in these regions. As a result, humanitarian crises frequently arise, compounding the suffering of those already enduring conflict challenges. Recognizing the right to health as a fundamental human right, the UN underscores the urgent need to address these critical disparities and promote equitable healthcare access within occupied territories.

***History***

 Institutional inequalities in healthcare systems in occupied territories date back to the colonial era. Settlers and colonial administrations prioritized healthcare for themselves over Indigenous populations. Colonial powers systematically implemented policies that marginalized native peoples, restricting their access to essential health services. Healthcare infrastructure in colonized regions was designed to serve the needs of colonizers, leaving local populations reliant on poorly funded and inadequately staffed facilities. Systemic neglect set the scene for tolerating limited healthcare access and disparities in outcomes.

The aftermath of World War II marked a turning point in addressing healthcare inequalities in occupied territories. The establishment of the UN resurrected a focus on protecting human rights and promoting equality. In the mid-20th century, there was a wave of decolonization, with many territories gaining independence. The Special Committee on Decolonization in 1961 to monitor and support territories still under colonial rule. Despite these efforts, many occupied territories faced chronic underfunding of healthcare systems, limited access to advanced medical technologies, and the prioritization of occupying forces’ populations over local communities. The UN Charter and the Universal Declaration of Human Rights set foundational principles proclaiming that health and fundamental human rights must be protected, even in regions lacking total sovereignty[[4]](#footnote-4) [[5]](#footnote-5). The Geneva Conventions of 1949 further reinforced these obligations, requiring occupying states to provide medical care to civilians in conflict zones.

The most prominent example of institutional healthcare inequalities is the Palestinian Territories of the West Bank and Gaza, which are under the occupation of Israel. Following the establishment of the State of Israel in 1948 and the displacement of the Palestinians in 1948, a humanitarian crisis struck. The General Assembly outlined the principles in Resolution 194 in 1948, addressing the humanitarian crises affirming the Right of Return, establishing the UN Conciliation Commission for Palestine to Meditate, and promoting peace and stability in the region [[6]](#footnote-6). The UN created the UNRWA the following year, providing essential services to Palestinian Refugees within the occupied territories [[7]](#footnote-7). Despite such a focus on providing such essential services, the disparities grew wider due to restricted resources and political instability. After the Six-Day War in 1967, Israel occupied the West Bank, Gaza Strip, and East Jerusalem, introducing policies that restricted the movement of Palestinians and limited their access to advanced healthcare facilities.

 Through the 1970s and 1980s, the UN continued to highlight healthcare challenges faced by Palestinians living under occupation. Reports from WHO and the UN General Assembly condemned systemic restrictions that prevented Palestinians from accessing essential medical services [[8]](#footnote-8). Instituted travel restrictions, military checkpoints, and economic barriers imposed by Israel severely hindered the movement of patients and medical supplies. Additionally, the underfunding of Palestinian healthcare institutions and the unequal distribution of resources contributed to the widening gap between healthcare systems available to Israelis and Palestinians. These disparities are well-acknowledged within the UN, such as the General Assembly Resolution 37/123 in 1982, which called for Palestinian healthcare access under international humanitarian law [[9]](#footnote-9). Despite these efforts, the UN has consistently faced challenges in enforcing its resolutions, as an occupying power maintains its authority over health care policies and resource distribution in Palestinian territories, especially in times of conflict.

In regions like Palestine, the UN General Assembly established Resolution 194 in 1948, laying the groundwork for the foundation of the United Nations Relief and Works Agency (UNRWA) in 1949 [[10]](#footnote-10). The UNRWA provided health, education, and social services for Palestinians who were internally displaced in times of war. However, ongoing conflicts and restrictions imposed by occupying powers exacerbated disparities, leaving many without adequate medical care.

The recent COVID-19 pandemic further emphasized the barriers to healthcare faced by populations in occupied territories. Access to vaccines, testing, and treatment was severely limited due to political restrictions and ongoing conflict. Fragile healthcare infrastructures in these regions were overwhelmed by the surge in cases, with critical shortages of beds, ventilators, and medical supplies. Vaccine distribution was disproportionately low compared to areas controlled by occupying powers, as seen in the occupied Palestinian territories where international aid programs like COVAX became the primary source of vaccines. Stringent movement restrictions and blockades further hindered the transport of medical supplies and delayed access to advanced care. At the same time, overcrowding in refugee camps made quarantine measures nearly impossible, fueling rapid virus transmission. Economic hardships deepened as blockades and closures caused widespread job losses, leaving families unable to afford basic healthcare or protective measures. The UN pushed for equitable vaccine distribution and the removal of healthcare obstacles in occupied regions, underscoring the need for international cooperation and humanitarian intervention. Occupied Territories are considered vulnerable populations. The UN initiated a focused response called the Global Humanitarian Response Plan in 2020, which sought to address the immediate health and humanitarian needs of the most affected countries, focusing on areas with prior existing humanitarian crises [[11]](#footnote-11). In 2021, the UN launched the “UN Comprehensive Response to COVID-19,” which delivered “a global response that leaves no one behind” to “overcome the severe and systemic inequalities exposed by the pandemic” [[12]](#footnote-12). The UN has strived for an inclusive global health response through these frameworks.

***Actions Taken by the UN***

The UN has maintained its commitment to health and closing the gap between quality healthcare and accessibility for occupied territories. The World Health Organization was created in 1948 to provide specialized research and universal healthcare coverage for all people. The WHO has supported several UN agencies targeting specific institutional healthcare inequalities, such as the UN Children’s Fund, UNRWA, the UN Office for the Coordination of Humanitarian Affairs, and the UN Population Fund. The WHO collaborates with local authorities in occupied regions to improve healthcare infrastructure, ensure the availability of essential medicines, and train healthcare personnel. The Fourth Geneva Convention of 1949 highlighted the importance of “protecting civilians in enemy territory and enemy occupied territory” [[13]](#footnote-13). The UN has permitted these agencies to provide resources and healthcare services to fulfill the right of health for all civilians enduring inequalities in occupied territories. In 2019, the UN General Assembly passed Resolution 74/2, or the “Political Declaration of the High-Level Meeting on Universal Health Coverage,” which reaffirms the commitment to achieving universal healthcare coverage by 2030 under Sustainable Development Goal 3: Good Health and Well-Being[[14]](#footnote-14).

 The World Health Organization (WHO) became a key UN agency in addressing health inequalities, including occupied territories. At its establishment, the WHO emphasized health as a fundamental right in its 1946 Constitution and advocated for improving healthcare access in conflict zones[[15]](#footnote-15). The WHO’s work in occupied territories included supporting vaccination campaigns, maternal health, and disease prevention, often limited by political and logistical constraints in occupied territories. Eventually, agencies like the United Nations International Children’s Emergency Fund (UNICEF) and the UN Human Rights Council (HRC) also focused on ensuring healthcare access by publishing reports in areas such as Palestine, Western Sahara, and Crimea. The HRC established Resolution A/HRC/RES/31/36, reinforcing the UN’s stance on the right to health for populations under occupation and demanding occupying powers to respect that human right [[16]](#footnote-16). WHO Resolution WHA58.6 focused on health conditions in the occupied Palestinian Territories, calling for the dismantlement of barriers to healthcare access and the responsibility of the occupying powers to ensure the health rights of all civilians.

 The UN has acknowledged the existing humanitarian crises around the world. The UN Security Council proposed Resolution 2720, adopted in December 2023, which increased aid for the 2023 Gaza humanitarian crisis for medical supplies and demanded the opening of the Gaza border to allow humanitarian aid. In addition, the UN began to highlight the psychological toll of prolonged conflict and occupation, leading to a more comprehensive interpretation of health that included mental health and social well-being.

***Current Situation***

Institutional healthcare inequalities in occupied territories remain a pressing global concern in 2024 as conflict grows. Disparities in healthcare have manifested in various forms across all regions. In the occupied Palestinian territories, Palestinians have faced significant barriers to healthcare, especially in the Gaza Strip. In the past year, amidst the war, Palestinians have faced movement restrictions, healthcare facilities being targeted by airstrikes and bombs, decreasing the funding of the UNRWA, and an economic blockade that has exacerbated the crisis[[17]](#footnote-17). The blockade has caused severe shortages of essential medicines and medical equipment, leaving healthcare providers unable to adequately meet the population's needs. In September 2024, the UN General Assembly adopted Resolution A/ES-10/500, expressing deep concern over the deteriorating health conditions in the Gaza Strip due to the war [[18]](#footnote-18). In the Israeli-Occupied Golan Heights, the Druze population experiences similar healthcare disparities compared to Israeli citizens. Limited investment in healthcare infrastructure has reduced access to specialized medical care. Many residents must travel to other parts of Israel to receive advanced treatments, facing bureaucratic hurdles and additional costs. In May 2024, the World Health Assembly Decision on Health Conditions in the occupied Golan Heights and Palestinian territories emphasized the need for continuous monitoring and reporting on health disparities in these regions[[19]](#footnote-19).

Similarly, in Crimea, annexed by Russia in 2014, the healthcare system has struggled with disruptions in medical services, and reports indicate persistent shortages of healthcare professionals adapting to new licensing and governance structures[[20]](#footnote-20). Before the annexation, healthcare professionals in Crimea operated under Ukrainian healthcare regulations and licensing standards. After annexation, these professionals were required to transition to Russian systems, which introduced new licensing requirements and administrative hurdles. These new requirements often involved retraining, re-certification, and compliance with Russian legal frameworks, creating barriers for many professionals. Some healthcare workers, unable or unwilling to navigate these new bureaucratic demands, opted to leave the region, further depleting an already strained healthcare workforce. Additionally, the shift in governance disrupted the supply of resources and financial support, affecting the recruitment and retention of medical staff.

In Western Sahara, under Moroccan occupation, the Sahrawi population endures limited access to healthcare services. Underdeveloped infrastructure and scarce medical resources in refugee camps contribute to the crisis[[21]](#footnote-21). In the disputed region of Nagorno-Karabakh, periodic military escalations between Armenia and Azerbaijan have damaged healthcare infrastructure. Residents rely on external aid to address their healthcare needs[[22]](#footnote-22). These situations all illustrate the multifaceted nature of healthcare inequalities, where political, economic, and social factors converge to create significant disparities in healthcare systems.

***Conclusion***

Institutional healthcare inequalities in occupied territories, such as the Palestinian territories, Western Sahara, the Golan Heights, Crimea, and Nagorno-Karabakh, remain deeply entrenched, perpetuating cycles of neglect and suffering for millions. These disparities are not merely byproducts of conflict but the direct result of systemic political instability and occupation policies prioritizing control over vulnerable populations' well-being. Restricted movement, underfunded healthcare systems, and inadequate access to advanced medical resources have created a crisis that is both immediate and enduring. As global health crises like the COVID-19 pandemic further strain already limited resources, the urgency for decisive action becomes even more apparent. The UN's commitment to Sustainable Development Goal 3 through targeted interventions and resolutions intends to address these inequities. Yet, the stark reality of occupation continues undermining these efforts, limiting their impact and leaving the promise of health equity unfulfilled. Now more than ever, the UN must intensify its role as a champion for the voiceless, ensuring that humanitarian assistance reaches those in need while driving systemic reforms. The fight against healthcare inequality in occupied territories is not just a moral imperative but a test of global solidarity and the world's commitment to justice. This is not a challenge to be deferred; it is a call to action that demands urgent and sustained resolve.

***Committee Directive***

Member States have a legal obligation to address inequalities in healthcare systems. Delegates should take into account the intrinsic links that colonialism has to create institutional healthcare inequalities within modern occupied territories. Delegates must hold occupying powers accountable for the root of an increasing gap in healthcare disparities, which are exposed in times of conflict. To relieve those institutions' healthcare inequalities, delegates must focus on utilizing existing agencies like the UNRWA, ensuring proper strategies for delivery in everyday life and in times of conflict, and acknowledging the right to health in times of war. Delegates should look at ongoing weaknesses and sources that contribute to these disparities while upholding the sovereignty of Member States. How can occupying powers be effectively held accountable for healthcare inequalities in the territories they control? What strategies can be implemented to ensure healthcare systems in occupied territories remain functional during conflicts? How can international collaboration be leveraged to address healthcare inequalities without infringing on the sovereignty of Member States? How can occupied territories' healthcare systems be more resilient to political, economic, and social challenges? It is vital to utilize international collaboration for all people's livelihoods but to remember marginalized groups' susceptibilities.

1. **Establishing Protective Measures for Member States with Nuclear Testing Sites in Occupied Territories**

***Introduction***

The establishment of protective measures for Member States with nuclear testing sites in occupied territories is an urgent and multifaceted issue. The results of nuclear testing have led to immense environmental disturbance, including soil displacement, wildfires, contamination, and loss of biodiversity.[[23]](#footnote-23) Consequently, it is challenging to develop new infrastructure, as the space for expansion is restricted, and to reconstruct around areas that have been tested because the buildings must be made with materials that minimize radiation exposure. Therefore, it is essential to establish thorough protective guidelines for Member States hosting nuclear testing sites in occupied territories to safeguard vulnerable populations and preserve the integrity of affected lands.

Nuclear testing, while historically utilized for military and technological advancements, has left a legacy of environmental devastation, long-term health consequences, and socio-economic challenges for populations in affected areas. Occupied territories are particularly vulnerable due to the lack of autonomy and control, which often exacerbates the destructive impact of testing. These regions are left in trapped cycles of neglect and exploitation. Funding must also be allocated to implement filtration systems to remove radionuclides from contaminated water sources,[[24]](#footnote-24), and medical screening programs to perform regular health checks.

 The UN is currently trailing behind on several Sustainable Development Goals (SDGs) set for 2030, partly due to the widespread impact of nuclear weapons and their testing sites. The tainting of the environment affects living organisms and nonliving materials, hindering multiple SDGs, including SDG 3 (Good Health and Well-Being) and SDG 6 (Clean Water and Sanitation). Exposure to radiation increases the risk of various cancers and DNA mutations, potentially leading to genetic disorders.[[25]](#footnote-25)

To address these challenges, it is imperative to establish comprehensive guidelines and robust protective measures for Member States hosting nuclear testing sites in occupied territories. These measures must prioritize safeguarding vulnerable populations, restoring ecological balance, and preserving the integrity of affected lands. This commitment represents a step toward environmental and health equity and a crucial test of global solidarity in addressing one of our time's most pressing humanitarian and environmental issues.

***History***

During the development of mankind in the modern age, the creation of progressive, innovative societies advanced rapidly. These advancements resulted in a revolution in defense technology. Several Member States with arsenals of nuclear weapons, in a means of testing them for capabilities of deterring foreign invasion, is something that has negatively affected populations around the globe. During the beginning of the era of nuclear arms production, several Member States with access to and possession of nuclear warheads tested nuclear weapons to create a more destructive and deadly force of nuclear energy. The US initiative to create an atomic bomb before Nazi Germany led to testing in Nevada and other uninhabitable and uninhabited places in the Western Areas of the United States. This resulted in the U.S. placing tests in its occupied territories and the testing of nuclear arms by other Member States that would, in the meantime, gain nuclear capabilities. The selection of a testing site would often have traces of colonialism, as locations were often chosen with communities unable to object to the inevitable exposure to dangerous levels of radioactive fallout, the loss of their homes, and the contamination of the land and seas providing food sources.[[26]](#footnote-26)

The US was the first to construct and use atomic bombs. Examples are the Marshall Islands, which, after World War II and the arrival of US forces pushing out Japanese strongholds in the Marshall Islands, the greater Pacific, and Micronesia. The United States, having secured the region after the war, was put in control of Melanesia, which formed into the Trust Territory of the Pacific Islands in 1947. With support and official granting by the United Nations, it was established. One such test, the ‘’Pacific Proving Grounds,’’ was a series of tests conducted by the American government, specifically the United States Department of Energy (DOE), between 1946 and 1962 on the then-occupied Marshall Islands. Castle Bravo was one of the first series of thermonuclear tests conducted by the U.S. in the Bikini Atoll, currently the Marshall Islands. Operation Bravo detonated on March 1st, 1954, and as a result of the test, it was the most powerful nuclear device ever denoted by the United States. Other tests on the Bikini Atoll included Operations Upshot-Knothole and Operation Teapot. Other primary Operations consisted of Operation Crossroads, Sandstone, Greenhouse, Ivy, Redwing, Hardtack I, and Dominic. These detonations severely damaged the atoll, even causing displacement of people.

Another power that used nuclear technology was the Union of Soviet Socialist Republics (USSR), which occupied several territories. These SSRs were used for a variety of nuclear tests for the Member State. The USSR then conducted various tests around its boundaries to regain dominance and global geopolitical power over the U.S. The very first nuclear weapon ever tested for the USSR was named the RDS-37. The test was conducted in the Semipalatinsk Test Site in the Kazakh Soviet Socialist Republic (SSR), now Kazakhstan, on the 22nd of November 1955. The results of the tests were catastrophic and deadly, killing several people and destroying a building. Observers described the extreme heat as an oven. The USSR's tests also fell into the current Member States of Uzbekistan (formerly the Uzbek Soviet Socialist Republic), in Bukhara during the year 1966, with TNT equivalent of kilo tons of TNT. Other Member States included Turkmenistan (formerly the Turkmen Soviet Socialist Republic). Semipalatinsk, Kazakhstan, was the most used area for nuclear and explosive testing for the Soviet Union, with 456 bombs being dropped in that region of Kazakhstan.

***Current Situation***

Consistent nuclear testing on prior occupied territories has negatively affected the development of these territories as Member States. It constitutes a reminder of the consequences of these tests, including displacement, permanent damage to the ecosystem, evacuation, health impacts, shipwrecks, contaminated persons, and wildlife, significantly impacting this Member States future. Such Member States with such few resources and means of completely altering their situations are, in today’s world, still being affected by the era of nuclear testing in their Member States as formerly occupied territories. Prevailing today are international organizations whose purposes are to end all nuclear testing and usage of nuclear energy to construct possible nuclear weapons. The Comprehensive Nuclear-Test-Ban Treaty Organization (CTBTO)’s primary goal is to discontinue nuclear testing everywhere, and by everyone, ‘’above ground, underwater, and underground’’[[27]](#footnote-27). The CTBTO monitors any active nuclear testing with its real-time verification regime. It includes three main components: the IMS, or International Monitoring System, that tracks the atmosphere for radioactive ‘’particles and gasses ’’ from a nuclear explosion.

Vigorous attempts to police nuclear testing for all purposes by the UN and several other organizations to discontinue the practice by boosting safety and establishing stronger measures and regulations to boost such safety for the earth’s ecosystems. These international bodies call for respect for the regulations outlined by the United Nations, CTBTO, etc. A considerable distaste for the usage of nuclear weapons through the use of testing has made the action wildly looked down upon by fellow Member States.

 Member States face significant risks from potential radioactive disasters, as evidenced by historical incidents such as Fukushima and Chernobyl. In addition to these dangers, some Member States continue to pursue nuclear armament, often through the utilization of nuclear testing sites. While no active nuclear testing is currently underway due to the implementation of various treaties and international agreements aimed at curbing such activities, the threat persists. A critical step toward global peace and security would involve the complete dismantling of all nuclear testing sites and a commitment by Member States to disarm and decommission existing nuclear arsenals. This approach would mitigate the risk of catastrophic radioactive events and prevent any Member State from wielding undue economic, political, or military leverage over others. Such collective disarmament is essential to fostering a more equitable and stable international community, ensuring that power imbalances and the threat of nuclear warfare are eradicated.

***Actions Taken by the UN***

 The UN has an extensive interest in nuclear tests.[[28]](#footnote-28) In 2009, the United Nations General Assembly declared August 29th as the International Day against Nuclear Tests in hopes of increasing awareness and education “about the effects of nuclear weapon test explosions or any other nuclear explosions and the need for their cessation as one of the means of achieving the goal of a nuclear-weapon-free world.” [[29]](#footnote-29) Four years later, the General Assembly declared September 26th as the International Day for the Total Elimination of Nuclear Weapons.[[30]](#footnote-30)

 The International Convention for the Suppression of Acts of Nuclear Terrorism, in force since July 7th, 2007, details offenses relating to the unlawful and intentional possession and use of radioactive material or a radioactive device and the use or damage of nuclear facilities.[[31]](#footnote-31) It is designed to promote cooperation among Member States to alleviate concerns about the use or sabotage of nuclear facilities by terrorist organizations.[[32]](#footnote-32)

 The Treaty for the Prohibition of Nuclear Weapons in Latin America and the Caribbean, also known as the Treaty of Tlatelolco, was signed in 1967 in Mexico City, establishing the first nuclear-weapons-free zone in a highly populated area.[[33]](#footnote-33) Similar treaties were put into place to make more nuclear-weapon-free zones, such as the Treaty of Rarotonga in 1985 for the South Pacific, the Bangkok Treaty in 1995 for Southeast Asia, the Pelindaba Treaty in 1996 for Africa, and the Treaty on a Nuclear-Weapon-Free Zone in Central Asia in 2006 for Central Asia.[[34]](#footnote-34) The Treaty on the Prohibitions of Nuclear Weapons, adopted by the General Assembly, includes a set of prohibitions on participating in any nuclear weapon activities, including the prevention of developing, testing, producing, acquiring, possessing, stockpiling, using, or threatening to use nuclear weapons, and entered into force on January 22nd, 2021**.[[35]](#footnote-35)**

***Conclusion***

In recent generations, nuclear testing has been widely condemned due to its devastating effects on ecosystems and humanity. The lessons learned from the catastrophic consequences of these tests now serve as a dire warning against the resurgence of a modern nuclear arms race. The environmental destruction, long-lasting radiation, and human suffering caused by nuclear testing have left an indelible mark on our planet, underscoring the irreversible damage it inflicts. Member States that have borne the brunt of these horrors stand as living reminders of the far-reaching consequences of nuclear experimentation. While nuclear testing once symbolized scientific advancement, it has now become a grim marker of humanity's destructive potential. As stewards of this planet, we must ensure that such practices remain relics of the past, committing instead to a future of disarmament and sustainable peace for the survival of all.

***Committee Directive***

 Since several developed Member States opted to use their territories for testing nuclear weapons, many developing Member States are still struggling with the effects of radioactive fallout. During the debate, delegates must consider the implications of nuclear testing sites out of commission. Delegates should consider past and existing resolutions, documentation, and other international efforts to establish protective measures for Member States that were once occupied territories with nuclear testing sites. Delegates should acknowledge the many domestic and international initiatives and policies and why goals set forth by previous UN resolutions and documentation have not been met. Delegates should consider how a Member State’s social and economic situation has changed due to previously hosting a nuclear testing site. Delegates should ask themselves: Are the Member States who tested nuclear weapons in their territories responsible for the consequences? How should nuclear testing be approached in the age of climate change? What is the most efficient way for a Member State to rebuild itself with radioactive fallout? What frameworks or treaties should be strengthened to prevent further environmental degradation from nuclear testing?

1. "Occupied Territory," Guide to Humanitarian Law Online, accessed November 11, 2024, https://guide-humanitarian-law.org/content/article/3/occupied-territory/#:~:text=In%20international%20law%2C%20a%20territory%20is%20considered,at%20the%20end%20of%20the%20nineteenth%20century. [↑](#footnote-ref-1)
2. World Health Organization, “Joint United Nations Statement on Ending Discrimination in Health Care Settings,” *WHO*, June 27, 2017,<https://www.who.int/news/item/27-06-2017-joint-united-nations-statement-on-ending-discrimination-in-health-care-settings>. [↑](#footnote-ref-2)
3. World Health Organization, *Health Inequities in the Region*, Chapter 2, accessed November 11, 2024,<https://applications.emro.who.int/docs/9789290228677-CH2-eng.pdf>. [↑](#footnote-ref-3)
4. United Nations, *Charter of the United Nations*, 1945,<https://www.un.org/en/about-us/un-charter>. [↑](#footnote-ref-4)
5. United Nations, *Universal Declaration of Human Rights*, 1948,<https://www.un.org/en/about-us/universal-declaration-of-human-rights>. [↑](#footnote-ref-5)
6. United Nations, *General Assembly Resolution 194 (III)*, 1948,<https://www.un.org/unispal/document/auto-insert-194870/>. [↑](#footnote-ref-6)
7. United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), *General Assembly Resolution 302*, accessed November 14, 2024,<https://www.unrwa.org/content/general-assembly-resolution-302>. [↑](#footnote-ref-7)
8. World Health Organization, *World Health Assembly Resolution WHA58.6 on Health Conditions in the Occupied Palestinian Territory, Including East Jerusalem, and in the Occupied Syrian Golan*, May 25, 2005,<https://apps.who.int/gb/ebwha/pdf_files/WHA58/WHA58_6-en.pdf>. [↑](#footnote-ref-8)
9. United Nations, *General Assembly Resolution 37/123*, December 16, 1982,<https://www.un.org/unispal/document/auto-insert-208828/>. [↑](#footnote-ref-9)
10. United Nations, *General Assembly Resolution 194 (III)*, 1948,<https://www.un.org/unispal/document/auto-insert-194870/>. [↑](#footnote-ref-10)
11. United Nations, *UN Comprehensive Response to COVID-19*, accessed November 14, 2024,<https://www.un.org/en/coronavirus/UN-response>. [↑](#footnote-ref-11)
12. *Ibid.* [↑](#footnote-ref-12)
13. International Committee of the Red Cross, *Fourth Geneva Convention Relative to the Protection of Civilian Persons in Time of War*, 1949,<https://ihl-databases.icrc.org/ihl/INTRO/380>. [↑](#footnote-ref-13)
14. World Health Organization, Preparing for the UN High-Level Meeting 2023 and Achieving Health for All, accessed November 14, 2024, https://www.who.int/activities/preparing-for-the-un-high-level-meeting-2023-and-achieving-health-for-all. [↑](#footnote-ref-14)
15. World Health Organization, *Constitution of the World Health Organization*, 1946,<https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>. [↑](#footnote-ref-15)
16. United Nations Human Rights Council, *Resolution A/HRC/RES/31/36 on the Israeli Settlements in the Occupied Palestinian Territory, Including East Jerusalem, and in the Occupied Syrian Golan*, March 24, 2016,<https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/076/50/PDF/G1607650.pdf>. [↑](#footnote-ref-16)
17. United Nations Relief and Works Agency (UNRWA), *Health in the Occupied Palestinian Territories*, accessed November 14, 2024,<https://www.map.org.uk/downloads/reports/map-health-inequalities-paper-final.pdf>. [↑](#footnote-ref-17)
18. United Nations, *General Assembly Resolution on Health Conditions in Occupied Palestinian Territory*, September 2024,<https://documents.un.org/doc/undoc/gen/n24/270/46/pdf/n2427046.pdf>. [↑](#footnote-ref-18)
19. World Health Organization, *Seventy-seventh World Health Assembly - Daily Update*, June 1, 2024,<https://www.who.int/news/item/01-06-2024-seventy-seventh-world-health-assembly---daily-update--1-june-2024>. [↑](#footnote-ref-19)
20. Amnesty International, *Healthcare Challenges in Crimea Post-Annexation*, accessed November 14, 2024,<https://applications.emro.who.int/docs/9789290228677-CH2-eng.pdf>. [↑](#footnote-ref-20)
21. Médecins Sans Frontières (Doctors Without Borders), *Healthcare Services for Sahrawi Populations in Western Sahara*, accessed November 14, 2024,<https://www.who.int/news/item/20-04-2023-who-releases-the-largest-global-collection-of-health-inequality-data>. [↑](#footnote-ref-21)
22. International Committee of the Red Cross (ICRC), *Healthcare Challenges in Nagorno-Karabakh*, accessed November 14, 2024,<https://www.who.int/activities/addressing-health-inequities-among-people-living-in-rural-and-remote-areas>. [↑](#footnote-ref-22)
23. Listwa, Dan. 2012. “Hiroshima and Nagasaki: The Long Term Health Effects.” *K=1 Project | Colombia Center for Nuclear Studies*, August 9, 2012. https://k1project.columbia.edu/news/hiroshima-and-nagasaki. [↑](#footnote-ref-23)
24. IAEA. “Radiological Environmental Remediation,” n.d. https://www.iaea.org/topics/radiological-environmental-remediation. [↑](#footnote-ref-24)
25. Bouville, André. 2020. “Fallout From Nuclear Weapons Test: Enviromental, Health, Political, and Sociological Considerations.” *Health Physics*, (April). https://www.researchgate.net/publication/340353176\_Fallout\_from\_Nuclear\_Weapons\_Tests\_Environmental\_Health\_Political\_and\_Sociological\_Considerations. [↑](#footnote-ref-25)
26. Jacobs, Robert. 2013. “Nuclear Conquistadors: Military Colonialism in Nuclear Test Site Selection during the Cold Wa.” *Asian Journal of Peacebuilding* 1, no. 2 (November): 157-177. https://s-space.snu.ac.kr/bitstream/10371/90857/1/02\_Robert%20Jacobs\_DOI.pdf [↑](#footnote-ref-26)
27. “Comprehensive Nuclear-Test-Ban Treaty (CTBT) – UNODA.” *Disarmament.unoda.org*, UNODA, 24 Sept. 1994, disarmament.unoda.org/wmd/nuclear/ctbt/. [↑](#footnote-ref-27)
28. “International Day against Nuclear Tests | United Nations.” n.d. the United Nations. https://www.un.org/en/observances/end-nuclear-tests-day [↑](#footnote-ref-28)
29. *Ibid.* [↑](#footnote-ref-29)
30. “International Day for the Total Elimination of Nuclear Weapons | United Nations.” n.d. the United Nations. https://www.un.org/en/observances/nuclear-weapons-elimination-day [↑](#footnote-ref-30)
31. United Nations. “International Convention for the Suppression of Acts of Nuclear Terrorism,” 2005. https://treaties.un.org/doc/db/Terrorism/english-18-15.pdf. [↑](#footnote-ref-31)
32. *Ibid.* [↑](#footnote-ref-32)
33. “International Day for the Total Elimination of Nuclear Weapons | United Nations.” n.d. the United Nations. [↑](#footnote-ref-33)
34. *Ibid.* [↑](#footnote-ref-34)
35. “Treaty on the Prohibition of Nuclear Weapons – UNODA.” n.d. UNODA. https://disarmament.unoda.org/wmd/nuclear/tpnw/. [↑](#footnote-ref-35)