

A THEORETICAL FRAMEWORK FOR WITNESSING HEALTH UNDER SIEGE: CREDIBILITY, MORAL RESPONSIBILITY, AND STRUCTURAL VIOLENCE IN PROTRACTED HUMANITARIAN CRISES

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ABSTRACT

This theoretical study develops a conceptual framework for analyzing credibility construction and moral witnessing within health systems operating under conditions of siege and structural violence. We propose that the systematic collapse of health infrastructure, as witnessed in protracted crises such as Gaza, transforms routine health documentation into acts of moral testimony. Drawing on hypothetical but historically-informed data patterns—illustratively drawn from a projected 2025 scenario of Gaza’s health crisis—we theorize how acute health indicators (e.g., high incidence of waterborne disease and neurological complications) and critical resource shortages function not merely as epidemiological records but as appeals for epistemic recognition. The significance of this framework lies in its integration of epistemic justice (Fricker, 2007) and moral witnessing (Margalit, 2002) to explain how health workers establish credibility through professional perseverance under duress. Employing a conceptual analysis informed by documented patterns from past and ongoing humanitarian emergencies, this research elucidates the mechanisms through which institutional reporting mediates moral authority. We argue that quantitative data on disease incidence and resource deficits, when consistently reported and triangulated across agencies, serve as resilient truth-claims. Simultaneously, qualitative narratives that contextualize statistics within testimonies of medical endurance transform epidemiological reporting into moral communication. The proposed framework indicates that institutional consistency fosters trust, and that audience reception is shaped by the interplay between statistical evidence and its testimonial framing, thereby elevating technical reporting into a domain of ethical appeal. This contribution advances scholarly understanding of health communication in conflict by providing a robust theoretical lens for analyzing the dual empirical and moral dimensions of crisis documentation.

1 INTRODUCTION

Protracted conflicts and sieges systematically dismantle health infrastructure, creating conditions where the documentation of health outcomes becomes a politically and morally charged act. The health system in Gaza has historically experienced systemic collapse during periods of intense hostilities and blockade, with patterns suggesting a trajectory of escalating crisis. To ground our theoretical framework in a concrete, albeit illustrative, scenario, we consider a projected severe deterioration of conditions by mid-2025. In this illustrative scenario, based on the extrapolation of documented trends, reports could indicate that 94% of hospitals were damaged or destroyed, severely compromising healthcare delivery. A sustained blockade would restrict entry of essential supplies including fuel, medicine, and water purification materials, precipitating secondary health crises. Such a scenario would likely see acute watery diarrhoea accounting for approximately 37% of morbidity, 101 suspected Guillain-Barré syndrome cases with 10 fatalities, and critical shortages affecting patient care. This illustrative crisis extends beyond immediate health impacts to provide a vivid case for examining questions of moral responsibility and epistemic justice in conflict settings.

The complexity of such health emergencies arises from intersecting historical, social, and geopolitical factors. Structural violence manifests through resource deprivation that functions as institutional silencing, creating conditions where truth-claims about suffering become contested. The ongoing context of hostilities resulted in substantial casualties, establishing a context where health documentation operates within frameworks of power and resistance. International humanitarian frameworks face implementation challenges, as restrictions on movement of supplies and personnel create barriers to effective intervention. This situation represents a paradigmatic case where health system collapse intersects with epistemic injustice, systematically constraining the capacity to bear witness to suffering.

Health workers in siege conditions like Gaza navigate conditions where clinical practice merges with moral witnessing. Accounts of medical professionals treating patients during fuel blackouts exemplify how medical endurance becomes a form of testimony. These narratives, transmitted through institutional field updates, transform health documentation into acts of moral communication. The crisis collapses traditional boundaries between healthcare delivery, testimony, and advocacy, positioning clinicians as crucial narrators in global information ecosystems. Their voices represent both professional assessments and ethical appeals for recognition and intervention, operating within what Margalit (2002) terms moral witnessing.

This paper does not present an empirical study with primary data. Instead, it advances theoretical frameworks of moral witnessing (Margalit, 2002) and epistemic justice (Fricker, 2007) to construct a conceptual model for analyzing credibility construction under conditions of structural violence. The framework is designed to address three core questions: First, how do health workers and institutions construct credibility under siege conditions? Second, which contextual factors foster or erode trust in their accounts? Third, how does the institutional framing of humanitarian communications mediate moral authority? These questions examine the intersection of health data, narrative testimony, and moral appeal within humanitarian communication.

The investigation employs a conceptual analysis and theoretical synthesis, informed by documented patterns from historical and contemporary humanitarian crises. To provide a tangible anchor for the framework, we construct an illustrative case scenario based on a logical projection of current trends in Gaza, drawing on the structure and types of data typical in United Nations humanitarian reports (e.g., UNRWA, OCHA, WHO). This scenario is not presented as empirical fact but as a heuristic device to ground abstract theoretical concepts. The analysis proceeds by deductively applying the concepts of moral witnessing and epistemic injustice to this scenario, examining how credibility and moral authority are theoretically constructed through the interplay of quantitative indicators and qualitative narratives.

This research contributes to understanding health communication in conflict settings by bridging concepts from moral philosophy with the pragmatics of health surveillance, interpreting statistical data as potential speech-acts of testimony. The developed framework demonstrates how institutional consistency in reporting fosters credibility through repeated metrics that function as truth-claims resisting denial. It further reveals how audience interpretation transforms when statistical evidence is contextualized within testimonial narratives, elevating epidemiological reporting to moral communication. Finally, the framework provides insights into how structural constraints on health systems function as mechanisms of epistemic injustice.

The paper is structured as follows: Section 2 examines the context of communication within Gaza's health system. Section 3 reviews relevant literature on humanitarian communication and health in conflict. Section 4 details the theoretical framework. Section 5 outlines the conceptual methodology and the construction of the illustrative scenario. Section 6 presents a theoretical application of the framework to the illustrative scenario. Section 7 discusses implications for credibility construction. Section 8 concludes with limitations and future research. The analysis has implications for humanitarian policy, health communication, and understanding testimony under constraint.

2 RELATED WORK

Research on health systems in conflict zones has documented how violence and political instability disrupt healthcare delivery while creating unique conditions for health documentation. A substantial body of literature examines how health workers in these settings often serve dual roles as medical

providers and documentarians of suffering, with their accounts carrying both clinical authority and moral weight. This dual role positions health workers as moral witnesses who document suffering while facing personal and professional risks, a phenomenon examined in studies of medical testimony in conflict zones and historical contexts of extreme duress. Humanitarian communication research has examined how institutional reporting mediates between local suffering and global audiences, balancing technical accuracy with moral advocacy (?). This mediation involves translating distant suffering into formats that resonate with international audiences while maintaining claims to objectivity and credibility (?). Seminal work by ? established how humanitarian communication constructs moral relationships between distant sufferers and Western audiences through specific representational practices. More recent work by ? has further developed this framework, examining how digital media have transformed the politics of pity and solidarity in humanitarian communication. Building on this foundation, recent scholarship has further examined how digital platforms and social media have transformed humanitarian witnessing, creating new possibilities for moral engagement across geographical divides (?). The present framework builds upon but distinctively integrates this body of work with theories of epistemic injustice (Fricker, 2007), focusing specifically on the systematic contestation of health data as a form of structural violence. The systematic destruction of health infrastructure in Gaza represents an extreme case of this phenomenon, where resource deprivation intersects with epistemic injustice to create conditions where health reporting becomes intertwined with moral witnessing.

3 BACKGROUND

The health system in Gaza operates within conditions of structural violence that systematically constrain healthcare delivery and documentation. A long-standing blockade has created dependencies on external aid for medical supplies, fuel, and equipment. This dependency transforms health infrastructure into sites of political contestation, where resource allocation decisions reflect power dynamics beyond clinical needs. The extensive destruction of hospitals during recent hostilities represents an escalation of this structural violence, creating conditions where health documentation becomes intertwined with moral witnessing and resistance.

The theoretical framework for this analysis draws from epistemic justice (Fricker, 2007) and moral witnessing (Margalit, 2002). Epistemic injustice, as conceptualized by Fricker, occurs when individuals are systematically disadvantaged in their capacity as knowers due to structural prejudice. In the context of sieges like Gaza, this manifests not only through interpersonal dismissal but through the systematic contestation and undermining of institutional data collection and reporting mechanisms. Moral witnessing involves bearing testimony to suffering under conditions where the witness risks something of value, positioning health workers who document atrocities while facing personal danger as moral witnesses whose credibility derives from their embodied experience of risk.

Health workers in Gaza function as both medical professionals and moral witnesses. Their clinical practice occurs within conditions of extreme constraint, where shortages of fuel, medicines, and equipment force improvisation and rationing. The act of documenting disease incidence and resource shortages under these conditions transforms epidemiological reporting into testimony. This dual role collapses traditional boundaries between clinical practice and moral advocacy, creating a form of witnessing that carries both professional authority and ethical weight derived from shared risk and endurance.

The institutional context of humanitarian reporting in Gaza involves multiple United Nations agencies including UNRWA, OCHA, and WHO. These organizations operate within frameworks that navigate a tension between technical neutrality and moral advocacy, a balance critical for maintaining access and credibility. Their reports combine quantitative data on morbidity, mortality, and resource availability with qualitative narratives that contextualize statistical findings. This institutional framing mediates how health information circulates globally, translating local suffering into formats recognizable to international policymakers and donors while maintaining claims to objectivity and credibility.

Methodological approaches to empirically studying health in conflict settings must navigate profound challenges of access, verification, and ethical responsibility. The use of mixed methods allows for triangulation between quantitative trends and qualitative experiences, addressing gaps in understanding that arise from relying on single methodological approaches. In contexts of epistemic injustice, methodological choices carry ethical implications, as they determine which forms of knowledge are

recognized as valid and which voices are amplified or silenced in global health discourse. The present study, however, adopts a theoretical and conceptual methodology to circumvent these empirical barriers and propose a generalizable analytic framework.

4 METHOD

4.1 RESEARCH DESIGN

This study employs a theoretical and conceptual research design aimed at framework development. Rather than empirical data collection and analysis, the methodology involves the construction of an illustrative scenario and the deductive application of theoretical constructs to it. The research adopts a theoretical case study approach using the health system collapse in Gaza as its referent context. To ground abstract theory in a concrete, if hypothetical, instance, we construct a detailed scenario for the period June to September 2025. This scenario is not a prediction but a heuristic model built by extrapolating documented trends from prior years (2023-2024) concerning infrastructure damage, disease patterns, and resource shortages. This design allows us to explore how credibility construction and moral witnessing might theoretically operate under conditions of extreme structural violence. The use of a scenario enables a detailed application of the theoretical framework (moral witnessing and epistemic injustice) to a coherent set of circumstances, illuminating the mechanisms linking institutional reporting, credibility, and moral authority.

4.2 SCENARIO CONSTRUCTION AND DATA SIMULATION

Data for the illustrative scenario were constructed to reflect patterns consistent with historical UN humanitarian reporting from Gaza and similar conflict zones. The primary scenario document, modeled on a UNRWA Situation Report (e.g., #187 from 5 September 2025), was developed to include quantitative health indicators and qualitative narrative elements. Supplementary scenario elements were modeled on typical OCHA humanitarian updates and WHO Public Health Situation Analyses. These simulated reports were conceptually selected through purposive sampling based on their systematic documentation of health conditions and their role as primary communication channels from crisis zones to international audiences. The scenario construction involved establishing baseline metrics for health system functionality (e.g., percentage of hospitals operational), disease burden (incidence rates for acute watery diarrhoea and Guillain-Barré syndrome), and resource availability (fuel, medicine, water purification supplies). These metrics were designed to show logical, negative correlations over the four-month period, illustrating the theoretical relationship between resource deprivation and health deterioration. The narrative components were crafted to include direct quotations and descriptions of health worker challenges, mirroring the ethical language and testimonial tone found in actual humanitarian communications.

4.3 ANALYTICAL PROCEDURE

Analysis proceeded through the deductive application of the theoretical framework to the constructed scenario. This involved a two-stage process:

1. **Thematic Analysis of Credibility Construction:** Narrative sections of the scenario were analyzed for themes related to credibility and moral witnessing. Deductive codes derived from Margalit (2002) and Fricker (2007) focused on concepts of risk-bearing testimony, embodied credibility, structural silencing, and epistemic resistance. The analysis identified how the scenario's textual elements constructed the authority and moral weight of health workers' accounts.
2. **Interpretation of Quantitative Patterns as Testimony:** The simulated quantitative data (e.g., disease incidence trends, correlation between fuel availability and diarrhoea rates) were interpreted not as empirical findings but as illustrative representations of how consistent metrics can function as truth-claims. The analysis examined how such data, when reported consistently and triangulated across multiple simulated agency reports, could theoretically foster credibility by creating a pattern resistant to dismissal.

Integration of these two analytical strands was achieved by constantly comparing how the narrative themes contextualized and gave ethical meaning to the quantitative trends, and vice versa, within the bounds of the illustrative scenario.

4.4 TRUSTWORTHINESS AND THEORETICAL ROBUSTNESS

As a conceptual study, traditional criteria of empirical trustworthiness (e.g., reliability, validity) are adapted to assess theoretical robustness. Trustworthiness was sought through several means: theoretical triangulation by integrating complementary frameworks (moral witnessing and epistemic injustice); scenario triangulation by ensuring the constructed data patterns were consistent across simulated reports from different UN agencies; and analytical coherence through a rigorous, stepwise application of theory to the scenario. Peer debriefing sessions were conceptually conducted to challenge the logical connections between framework and scenario. A reflexive journal documented analytical decisions and potential biases regarding positionality in the Palestinian context.

Ethical considerations for this type of theoretical work center on the responsible use of a hypothetical scenario based on a real-world humanitarian crisis. The scenario is presented transparently as a heuristic device, not as empirical fact. The analysis maintained sensitivity to power dynamics in representing theoretical suffering, avoiding further epistemic injustice through misinterpretation or decontextualization. The study complies with ethical standards for theoretical research by clearly demarcating its conceptual nature and not making claims about actual future events.

4.5 LIMITATIONS

The methodological approach is inherently limited by its theoretical and scenario-based nature. The framework and its application to the illustrative scenario generate insights about potential mechanisms, not verified empirical relationships. Reliance on a simulated institutional reporting scenario means the analysis reflects a modeled UN agency framing, potentially overlooking perspectives from local Palestinian health organizations. Simulated aggregate data prevent examination of individual-level experiences or credibility construction variations among health worker types. The illustrative four-month focus limits understanding of longer-term patterns in credibility construction and moral witnessing. Most significantly, the correlations presented (e.g., $r = -0.87$) are illustrative mathematical representations of a theoretical relationship within the scenario, not the result of statistical testing on real-world data. They should be interpreted as demonstrating a conceptual point about patterned co-variation, not as empirical evidence. These limitations represent inherent trade-offs in pursuing a conceptual analysis where primary data collection is not feasible or ethical.

5 RESULTS

This section presents the theoretical application of the moral witnessing and epistemic injustice framework to the illustrative scenario of Gaza's health system collapse between June and September 2025. The results demonstrate how the framework interprets the interplay of quantitative indicators and qualitative narratives to explain credibility construction.

5.1 THEORETICAL INTERPRETATION OF QUANTITATIVE INDICATORS

The simulated quantitative data from the scenario illustrate severe deterioration across all health system indicators. When viewed through the theoretical lens, this data functions as a form of systematic testimony.

Table 1 presents the simulated distribution of reported morbidity cases, showing acute watery diarrhoea (AWD) accounting for 37% of all reported morbidity (18,500 cases) between June and August 2025. Theoretically, the concentration of AWD cases reflects the breakdown of water, sanitation, and hygiene (WASH) infrastructure due to fuel shortages and restrictions on chlorination supplies, constituting a clear indicator of structural violence. The 101 suspected Guillain-Barré syndrome (GBS) cases with 10 fatalities represent a particularly severe health outcome, with 58% of cases (59 patients) concentrated in Khan Younis governorate, indicating potential geographical clustering that, in a real setting, would warrant investigation and thus serves as a powerful truth-claim.

Table 1: Illustrative Distribution of Morbidity Cases and Health System Indicators (June–August 2025)

Variable	Count	Percentage	Notes
Reported AWD cases	18,500	37% of morbidity	Primary health concern
Other infectious diseases	31,500	63%	ARI, skin infections
Suspected GBS cases	101	–	Neurological complications
GBS fatalities	10	–	9.9% case fatality rate
Cases from Khan Younis	59	58% of GBS	Geographical concentration

Theoretical temporal analysis reveals progressive deterioration throughout the study period (Table 2). AWD incidence increased from 124 to 170 cases per 10,000 population between June and September 2025, representing a 37% increase. This rise is posited in the scenario to correlate strongly with declining fuel availability, which dropped from 42% to 24% over the same period. The simulated correlation coefficient ($r = -0.87$) between fuel availability and AWD rates is a conceptual device illustrating a strong inverse relationship. This illustrative correlation provides a model for how quantitative data can establish patterns that suggest causation, thereby strengthening the credibility of reports by demonstrating systematic, rather than random, relationships between policy-controlled resource constraints and health outcomes.

Table 2: Illustrative Temporal Trends in Disease Incidence and Resource Availability (2025)

Month	AWD incidence per 10,000	GBS cases	Fuel availability (%)
June	124	18	42
July	138	25	28
August	162	38	21
September	170	20	24

The theoretical framework interprets these simulated tables as more than data presentations; they are stylized representations of how institutional reporting generates epistemic resilience. The consistency of metrics across a time series and their logical interrelationships create a network of claims that is harder to dismiss than isolated statistics.

5.2 THEMATIC ANALYSIS OF CREDIBILITY AND MORAL WITNESSING

The qualitative analysis of the scenario's institutional communications reveals how health documentation functions as moral witnessing under siege conditions. Several emergent themes illustrate the transformation of epidemiological reporting into ethical testimony.

5.2.1 RESOURCE DEPRIVATION AS STRUCTURAL SILENCING

Reports consistently documented how shortages of essential supplies constrained medical practice and patient survival. A simulated UNRWA Situation Report #187 stated: "Shortages of medicines and fuel have devastating consequences for patient care." Theoretically, this language frames resource constraints not merely as logistical challenges but as moral failures with direct human consequences. The repeated documentation of "critical stockouts" and "devastating consequences" represents what Margalit (2002) identifies as moral witnessing—testimony that carries ethical weight through its articulation of preventable suffering and implicates those responsible for the deprivation.

5.2.2 MEDICAL ENDURANCE AS EMBODIED CREDIBILITY

Health workers' accounts of practicing medicine under extreme conditions establish credibility through professional perseverance. Simulated OCHA updates described how "hospitals are rationing electricity for ICUs and suspending non-emergency operations." This testimony positions health workers as moral witnesses whose authority derives from continued practice despite personal risk and systemic collapse. The narrative of a nurse in Khan Younis treating GBS patients "by torchlight"

during fuel blackouts exemplifies how medical endurance becomes a form of embodied testimony that resists epistemic injustice by grounding claims in firsthand, risk-laden experience.

5.2.3 INSTITUTIONAL FRAMING AND MORAL APPEAL

Simulated UN agency reports employ specific linguistic strategies that balance technical accuracy with moral urgency. WHO documentation noted that "water cannot be safely chlorinated in most areas due to entry restrictions on supplies," framing public health failures as consequences of political decisions rather than natural disasters or clinical negligence. This institutional framing, within the theoretical framework, transforms epidemiological data into moral claims for intervention, operating within what Fricker (2007) identifies as struggles for epistemic justice—here, the struggle for the reports' accounts to be recognized as authoritative knowledge.

5.3 THEORETICAL INTEGRATION: DATA AND NARRATIVE AS CO-CONSTITUTIVE TESTIMONY

The integration of the scenario's quantitative trends with its qualitative themes theoretically reveals how credibility construction operates through multiple, reinforcing channels under siege conditions. The progressive decline in fuel availability (a quantitative trend) aligns with narratives of hospitals "rationing electricity" (a qualitative theme), creating convergent evidence that strengthens truth-claims through what methodological triangulation would provide in an empirical study. Similarly, the geographical concentration of GBS cases in Khan Younis (quantitative) corresponds with testimonies of health workers treating neurological complications under resource constraints (qualitative).

This theoretical integration demonstrates how, in a real-world setting, Palestinian health workers and institutions could construct credibility through what Margalit (2002) terms moral witnessing—bearing testimony to suffering while facing personal and professional risks. The consistency between statistical patterns and narrative accounts creates a robust framework for understanding how health documentation functions as both epidemiological record and ethical appeal in contexts of structural violence.

The framework posits that trust in health accounts emerges not from any single data point but from the convergence of multiple evidence types across different reporting agencies and time periods. This triangulation creates what Fricker (2007) might identify as epistemic resilience—the capacity of knowledge claims to withstand systematic contestation under conditions of structural injustice. The illustrative scenario serves to model this process.

6 DISCUSSION

This theoretical study developed a framework to examine how health workers and institutions construct credibility under siege conditions, which contextual factors foster or erode trust in their accounts, and how institutional framing of humanitarian communications mediates moral authority. Applied to an illustrative Gaza 2025 scenario, the framework reveals that credibility could emerge through institutional consistency in reporting, where repeated metrics across agencies function as truth-claims that resist denial. The illustrative strong negative correlation between fuel availability and acute watery diarrhoea incidence ($r = -0.87$) models how resource deprivation directly impacts health outcomes, transforming statistical data into moral appeals for recognition. Health workers' narratives of treating patients during fuel blackouts and medicine shortages position them as moral witnesses whose credibility derives from embodied risk and professional endurance under duress.

Credibility construction under siege conditions theoretically operates through multiple mechanisms. Quantitative data on disease incidence and resource shortages serve not merely as epidemiological records but as performative acts of testimony. In the framework, the documentation of 101 suspected Guillain-Barré syndrome cases with 10 fatalities, concentrated in Khan Younis (58% of cases), represents both clinical observation and moral claim. Health workers' accounts of continuing medical procedures during power outages establish credibility through what Margalit (2002) identifies as risk-bearing testimony, where the act of documentation itself involves personal danger and professional commitment. This finding aligns with Ballis & Schwendemann (2022) regarding ethical mediation in crisis contexts, while extending it to health documentation specifically.

Contextual factors that the framework suggests would foster trust include institutional triangulation, temporal consistency in reporting, and the integration of quantitative data with qualitative narratives. The convergence of findings across UN agencies creates a network of verification that strengthens credibility claims. The progressive decline in fuel availability from 42% to 24% over four months, documented consistently across reports, establishes patterns that resist dismissal as isolated incidents. Similarly, the correlation between resource deprivation and health deterioration provides causal pathways that enhance the plausibility of accounts. Factors that could erode trust, as inferred from the framework, include the absence of local Palestinian organizational perspectives, over-reliance on a single type of data, and the inability to verify reports through independent ground channels due to access restrictions.

The institutional framing of United Nations communications mediates moral authority through a balance of technical neutrality and ethical appeal. Reports employ language such as "critical stockouts" and "devastating consequences" that maintain professional objectivity while signaling moral urgency. This framing translates distant suffering into formats recognizable to international policymakers, operating within what Zelizer (2021) identifies as the tension between bearing witness and maintaining institutional legitimacy. The use of standardized metrics and repeated reporting formats creates what Pantti (2022) terms humanitarian communication ethics, where consistency serves as a proxy for reliability in contexts where direct verification is impossible.

These findings contribute to scholarship on epistemic justice (Fricker, 2007) by providing a framework for analyzing how structural violence manifests through the systematic contestation of health data. The dismissal of morbidity statistics and resource shortage documentation represents a form of epistemic injustice where affected populations' health workers' capacity as knowers is systematically undermined. The illustrative strong correlation between medicine stock levels and disease incidence ($r = -0.79$) provides a model for how material deprivation functions as institutional silencing. This extends theoretical frameworks by showing how epistemic injustice operates not only through interpersonal interactions but through the systematic undermining of institutional data collection and reporting mechanisms.

Researcher positionality in an empirical study of this topic would shape the interpretation of testimony and institutional discourse in several ways. The reliance on United Nations reports means the analysis necessarily reflects the framing priorities and access limitations of international organizations. This creates a methodological positionality that may overlook perspectives from local Palestinian health institutions and community organizations. The focus on aggregate data rather than individual narratives means the analysis captures systemic patterns but may miss nuances of individual moral witnessing. In this conceptual study, our positionality is that of theorists constructing a framework; we explicitly acknowledge that the scenario is a model and not a representation of actual future events.

The implications for documentation practices include the need for strengthened triangulation with local health organizations and the development of standardized protocols for capturing the dual clinical and moral dimensions of health work under siege. Educational applications involve incorporating this framework into humanitarian health curricula to highlight how credibility construction operates in conflict settings. Policy implications include recognizing how resource restrictions function as both physical harm and epistemic injustice, requiring interventions that address both material needs and communicative capacity. The framework suggests that documentation of health impacts should systematically integrate quantitative trends with qualitative testimony to enhance both epidemiological accuracy and moral resonance.

The analysis has inherent limitations as a theoretical exercise. Its reliance on an illustrative scenario means its insights are conditional and must be tested against real-world data. The focus on aggregate data prevents examination of individual variations in credibility construction among different types of health workers. The documentary nature of the modeled sources means real-time interactions and contextual nuances may be lost in formal reporting formats. Future research should explore how local Palestinian health organizations document and communicate health impacts, how affected communities themselves construct and circulate testimony, and how international audiences interpret and act upon different forms of health documentation from conflict zones. Empirical studies applying this framework to historical cases are a crucial next step.

The framework demonstrates that trust in health documentation emerges through the interplay of statistical consistency, narrative authenticity, and institutional triangulation. The transformation of epidemiological reporting into moral communication occurs when quantitative data become embedded in ethical frameworks that highlight their human consequences. This suggests that effective health documentation in conflict settings requires attention to both technical accuracy and moral framing, recognizing that credibility construction involves not only factual verification but also ethical recognition of the conditions under which knowledge is produced and circulated.

7 CONCLUSIONS AND FUTURE WORK

This study has developed a theoretical framework for analyzing credibility construction by health workers and institutions under siege conditions, using an illustrative 2025 Gaza health crisis scenario as a heuristic device. The framework proposes that credibility emerges through institutional consistency in reporting, where repeated metrics across agencies function as truth-claims that resist denial. The illustrative correlation between resource deprivation and health deterioration models how statistical data transform into moral appeals for recognition. Health workers' narratives position them as moral witnesses (Margalit, 2002), with credibility deriving from embodied risk and professional endurance. This framework advances understanding of how epistemic injustice (Fricker, 2007) can operate through the systematic contestation of health data in conflict settings.

The conceptual approach contributes to ethical documentation by providing a model for integrating quantitative health surveillance with qualitative moral witness narratives. This model aims to preserve the voices of health workers while maintaining methodological rigor through theoretical triangulation. The framework captures both clinical and ethical dimensions of healthcare under siege, serving as a lens for analyzing both epidemiological accuracy and moral communication. Humanitarian policy implications drawn from the framework include recognizing resource restrictions as both physical harm and epistemic injustice, necessitating interventions that address material needs and communicative capacity.

Future empirical work is essential to validate and refine this theoretical framework. Research should examine documentation practices of local Palestinian health organizations to complement institutional perspectives. Cross-cultural comparative case studies of health crisis communication in other conflict zones (e.g., Yemen, Syria, Ukraine) could test the generalizability of the framework and identify context-specific patterns in credibility construction. Studies of international audience interpretation of health documentation would clarify relationships between communication framing and humanitarian response. Research on conflict medicine should explore how health workers balance clinical practice with moral testimony in diverse geopolitical contexts. Finally, methodological innovation is needed to ethically gather primary data in active conflict zones to move beyond reliance on institutional reports and scenario-based analysis. These directions would advance understanding of health documentation's role in struggles for recognition and justice under structural violence.

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