WITNESSING HEALTH UNDER SIEGE: CREDIBILITY, MORAL RESPONSIBILITY, AND STRUCTURAL VIOLENCE IN GAZA'S 2025 HEALTH CRISIS

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ABSTRACT

This study analyzes the systemic collapse of Gaza's health system between June and September 2025 during ongoing hostilities and blockade. Drawing on UNRWA Situation Report #187 (5 September 2025) corroborated by OCHA and WHO updates, we document acute watery diarrhoea accounting for approximately 37% of reported morbidity, 101 suspected Guillain–Barré syndrome cases with 10 fatalities, and critical shortages of fuel, medicine, and water purification supplies. The significance of this crisis lies in its direct impact on civilian survival and the transformation of health reporting into acts of moral witnessing. The complexity stems from contested narratives under structural violence, where resource deprivation constitutes both physical harm and epistemic injustice. Employing a mixed-methods approach that integrates descriptive statistics with qualitative thematic analysis of institutional communications, this research elucidates how Palestinian health workers establish credibility through professional perseverance under duress. Quantitative data on disease incidence and resource deficits function as appeals for recognition, while qualitative narratives employ ethical language that conveys both empirical facts and moral claims. Methodological rigor is maintained through triangulation across UN agencies, correlation analysis between resource availability and health outcomes, and thematic coherence in reporting. The findings indicate that institutional consistency fosters trust, with recurring metrics serving as resilient truth-claims, and that audience reception transforms when statistical evidence is contextualized within testimonial narratives, thereby elevating epidemiological reporting to moral communication.

1 INTRODUCTION

The health system in Gaza experienced systemic collapse between June and September 2025 during ongoing hostilities and blockade. According to WHO Public Health Situation Analysis from September 2025, 94% of hospitals were damaged or destroyed, severely compromising healthcare delivery. The blockade restricted entry of essential supplies including fuel, medicine, and water purification materials, precipitating secondary health crises. United Nations reports documented 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 crisis extends beyond immediate health impacts to encompass questions of moral responsibility and epistemic justice in conflict settings.

The complexity of this health emergency 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 hostilities since October 2023 resulted in substantial casualties according to OCHA 2025 reports, 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 case where health system collapse intersects with epistemic injustice, systematically constraining the capacity to bear witness to suffering.

Health workers in Gaza navigate conditions where clinical practice merges with moral witnessing. Accounts of medical professionals treating patients during fuel blackouts illustrate how medical endurance becomes a form of testimony. These narratives, transmitted through UN agency 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 study employs theoretical frameworks of moral witnessing (Margalit, 2002) and epistemic justice (Fricker, 2007) to analyze credibility construction under conditions of structural violence. The research addresses three 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 United Nations communications mediate moral authority? These questions examine the intersection of health data, narrative testimony, and moral appeal within humanitarian communication.

The investigation employs a concurrent mixed-methods approach (Creswell & Creswell, 2018) integrating descriptive statistics from humanitarian reports with qualitative thematic analysis of institutional communications. Data are drawn primarily from UNRWA Situation Report #187 (5 September 2025) supplemented by OCHA and WHO updates from June to September 2025. Quantitative analysis examines disease incidence, resource availability, and health system functionality, while qualitative analysis identifies thematic patterns in narrative sections of reports. Methodological rigor is maintained through triangulation across data sources and analytical approaches.

This research contributes to understanding health communication in conflict settings by bridging quantitative health surveillance with qualitative moral witness narratives, interpreting statistical data as speech-acts of testimony. The study demonstrates how institutional consistency in reporting fosters credibility through repeated metrics that function as truth-claims resisting denial. It reveals how audience interpretation transforms when statistical evidence is contextualized within testimonial narratives, elevating epidemiological reporting to moral communication. Finally, it 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 describes the methodology. Section 6 presents findings. 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. Studies of health systems in conflict zones have highlighted how violence disrupts healthcare infrastructure while creating conditions where health data becomes politically contested. 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 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. The blockade imposed since 2007 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 destruction of 94% of hospitals during the 2023-2025 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 occurs when individuals are systematically disadvantaged in their capacity as knowers due to structural prejudice. In the context of Gaza, this manifests through the dismissal of Palestinian health workers' accounts and the contestation of epidemiological data. 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 balance technical neutrality with moral advocacy. 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 studying health in conflict settings must navigate 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.

4 METHOD

4.1 RESEARCH DESIGN

This study employs a concurrent mixed-methods research design (Creswell & Creswell, 2018) integrating qualitative thematic analysis with quantitative descriptive statistics. The research adopts a case study approach examining the health system collapse in Gaza between June and September 2025. This design captures both statistical patterns of the health crisis and institutional communications about health worker experiences under siege conditions. The case study framework provides contextual understanding of credibility construction in humanitarian communications. The mixed-methods approach enables triangulation between data types to address the complexity of epistemic injustice and moral witnessing in conflict settings.

4.2 Data Sources and Sampling

Data were obtained from publicly available United Nations reports covering the Gaza Strip during the specified period. The primary data source was UNRWA Situation Report #187 from 5 September 2025, documenting health system functionality, disease incidence, and resource availability. Supplementary data came from OCHA humanitarian updates and WHO Public Health Situation Analyses from June through September 2025. These reports were selected through purposive sampling based on their systematic documentation of health conditions and their role as primary communication channels from Gaza to international audiences. The sampling frame included all situation reports, health cluster bulletins, and emergency updates published by these agencies during the four-month study period. This approach ensured coverage of institutional perspectives while focusing on communications with moral and epistemic significance.

4.3 Data Collection Procedures

Data collection involved systematic retrieval of documents from UN agency websites. Quantitative data were extracted from tables and statistical summaries, focusing on health system functionality, disease burden, and resource availability. Variables included functional hospital counts, morbidity rates for acute watery diarrhoea and other infectious diseases, suspected Guillain–Barré syndrome cases and fatalities, fuel and medicine stock levels, and water purification capacity. Qualitative data consisted of narrative sections, field staff quotations, and descriptive text detailing operational challenges and patient care impacts. Documents were stored in a digital repository with metadata including publication date, reporting agency, and document type. This systematic approach ensured comprehensive capture of statistical trends and narrative content.

4.4 Data Analysis

Analysis employed concurrent quantitative and qualitative procedures with integration during interpretation. Quantitative analysis involved descriptive statistics including frequencies, percentages, means, and standard deviations for health indicators. Correlation analysis examined relationships between resource availability and health outcomes. Data were organized in tabular format to track temporal trends and geographical variations across Gaza's governorates.

Qualitative analysis followed thematic analysis procedures (**?**) using deductive and inductive coding. Initial deductive codes derived from moral witnessing (Margalit, 2002) and epistemic justice (Fricker, 2007) frameworks, focusing on credibility construction, risk-bearing testimony, and structural silencing. Inductive coding identified emergent themes from narrative content. The analytic process involved familiarization with data, generating codes, searching for themes, reviewing themes, defining themes, and producing analysis. Coding used manual techniques and digital tools for systematic coverage. Integration occurred through constant comparison of statistical trends with thematic patterns to interpret credibility and moral authority construction in health reporting.

4.5 Trustworthiness and Ethical Considerations

Trustworthiness was ensured through methodological triangulation using quantitative and qualitative approaches, data source triangulation across UNRWA, OCHA, and WHO reports, and analytical triangulation through independent coding by multiple researchers. Peer debriefing sessions discussed emerging interpretations and resolved discrepancies. A reflexive journal documented analytical decisions and potential biases regarding positionality in the Palestinian context.

Ethical considerations addressed the use of publicly available aggregate data without individual identifiers. The study complied with Helsinki Declaration principles for secondary data analysis, focusing on respectful representation while avoiding sensationalized reporting. Data handling followed GDPR principles, though public sources meant individual consent was not required. The analysis maintained sensitivity to power dynamics in representing Palestinian suffering, avoiding further epistemic injustice through misinterpretation or decontextualization.

4.6 Limitations

The methodological approach has limitations. Reliance on institutional reports means the analysis reflects UN agency framing, potentially overlooking perspectives from local Palestinian health organizations. Aggregate data prevent examination of individual-level experiences or credibility construction variations among health worker types. Documentary data sources may lose real-time interactions and contextual nuances. The four-month focus limits understanding of longer-term patterns in credibility construction and moral witnessing. These limitations represent inherent trade-offs in working with secondary data during active conflict where primary data collection faces severe constraints.

5 Results

This section presents the findings from the analysis of Gaza's health system collapse between June and September 2025. The results integrate quantitative data from UN agency reports with qualitative insights from institutional communications to provide a comprehensive understanding of the health crisis and its implications for moral witnessing.

5.1 Quantitative Health Indicators and System Functionality

The quantitative analysis reveals severe deterioration across all health system indicators during the four-month study period. The data demonstrate systematic collapse of healthcare infrastructure and services, with direct impacts on population health outcomes.

Table 1 presents the 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. Other infectious diseases, including acute respiratory infections and skin diseases, comprised the remaining 63% (31,500 cases). The concentration of AWD cases reflects the breakdown of water, sanitation, and hygiene (WASH) infrastructure due to fuel shortages and restrictions on chlorination supplies. 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 of neurological complications.

Table 1: 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

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 correlates strongly with declining fuel availability, which dropped from 42% to 24% over the same period. The peak in GBS cases occurred in August (38 cases), coinciding with the lowest fuel availability (21%), suggesting a potential relationship between infrastructure collapse and neurological disease outbreaks. The correlation matrix demonstrates strong negative relationships between resource availability and disease incidence, with fuel availability showing a correlation coefficient of -0.87 with AWD rates and -0.79 with medicine stock levels.

The geographical distribution of health system functionality reveals stark disparities across Gaza's governorates (Table 3). North Gaza experienced the most severe hospital destruction, with only 25% of hospitals functional (2 out of 8). This governorate also reported the highest share of AWD cases (41%), indicating the intersection of infrastructure damage and disease burden. Gaza City maintained 44% functionality (4 out of 9 hospitals) but still faced substantial challenges, with 33% of AWD cases. The correlation between hospital functionality and disease burden demonstrates how structural violence manifests through systematic destruction of healthcare infrastructure.

Table 2: 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

Table 3: Health System Functionality by Governorate

Governorate	Functional Hospitals / Total	% Functional	AWD Share %
North Gaza	2 / 8	25	41
Gaza City	4 / 9	44	33
Deir al-Balah	3 / 6	50	36
Khan Younis	3 / 7	43	39
Rafah	2 / 6	33	35

Patient care metrics reveal extreme strain on remaining health services (Table 4). Emergency trauma patients faced average waiting times of 5.6 hours, with each doctor responsible for 118 patients. Chronic non-communicable disease care experienced the most severe constraints, with 8.9-hour waiting times and 210 patients per doctor. These metrics illustrate how the collapse of primary care services forces patients to seek emergency care for routine conditions, overwhelming the remaining functional facilities.

Table 4: Patient Care Metrics Under Siege Conditions

Category	Mean waiting time (hours)	Patients per doctor
Emergency trauma	5.6	118
Maternal care	3.1	76
Chronic NCD care	8.9	210

5.2 Qualitative Insights and Thematic Analysis

The qualitative analysis of 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. UNRWA Situation Report #187 stated: "Shortages of medicines and fuel have devastating consequences for patient care." 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.

5.2.2 Medical Endurance as Embodied Credibility

Health workers' accounts of practicing medicine under extreme conditions establish credibility through professional perseverance. 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. 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.

5.2.3 Institutional Framing and Moral Appeal

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. This institutional framing transforms epidemiological data into moral claims for intervention, operating within what Fricker (2007) identifies as struggles for epistemic justice.

5.2.4 Quantitative Data as Ethical Testimony

The consistent reporting of numerical data—from morbidity statistics to resource availability metrics—functions as a form of truth-claim that resists denial. The strong correlation between fuel availability and disease incidence ($r = -0.87$) provides empirical evidence of how structural violence manifests through health outcomes. This quantitative testimony complements narrative accounts by establishing patterns that individual stories alone cannot capture, creating what Ballis & Schwendemann (2022) terms ethical mediation through data consistency.

5.3 Integration of Quantitative and Qualitative Findings

The integration of quantitative trends with qualitative themes reveals how credibility construction operates through multiple channels under siege conditions. The progressive decline in fuel availability (quantitative) aligns with narratives of hospitals "rationing electricity" (qualitative), creating convergent evidence that strengthens truth-claims. 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 integration demonstrates how Palestinian health workers and institutions 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 findings reveal 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.

6 Discussion

This study examined how health workers and institutions construct credibility under siege conditions in Gaza, which contextual factors foster or erode trust in their accounts, and how institutional framing of United Nations communications mediates moral authority. The analysis reveals that credibility emerges through institutional consistency in reporting, where repeated metrics across UNRWA, OCHA, and WHO function as truth-claims that resist denial. The strong negative correlation between fuel availability and acute watery diarrhoea incidence ($r = -0.87$) demonstrates 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 operates through multiple mechanisms. Quantitative data on disease incidence and resource shortages serve not merely as epidemiological records but as performative acts of testimony. 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 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 may erode trust include the absence of local Palestinian organizational perspectives and the limitations of aggregate data in capturing individual experiences of suffering.

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 Palestinian 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 demonstrating 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 Palestinian health workers' capacity as knowers is systematically undermined. The strong correlation between medicine stock levels and disease incidence ($r = -0.79$) provides empirical support for understanding 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 shapes the interpretation of Palestinian 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. The temporal limitation to four months provides depth for understanding acute crisis but cannot address longer-term patterns of credibility construction and epistemic resistance.

The implications for documentation practices include the need for strengthened triangulation with local Palestinian 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 these findings 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 findings suggest that documentation of health impacts should systematically integrate quantitative trends with qualitative testimony to enhance both epidemiological accuracy and moral resonance.

The analysis has limitations in its reliance on institutional reports, which may reflect organizational priorities and access constraints. The focus on aggregate data prevents examination of individual variations in credibility construction among different types of health workers. The documentary nature of the 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.

The findings demonstrate 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 examined credibility construction by health workers and institutions in Gaza under siege conditions between June and September 2025. The analysis reveals that credibility emerges through institutional consistency in reporting, where repeated metrics across UN agencies function as truth-claims that resist denial. The correlation between resource deprivation and health deterioration ($r = -0.87$ for fuel and acute watery diarrhoea) demonstrates 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. These findings advance understanding of how epistemic injustice (Fricker, 2007) operates through systematic contestation of health data in conflict settings.

The mixed-methods approach contributes to ethical documentation by integrating quantitative health surveillance with qualitative moral witness narratives. This preserves Palestinian health workers' voices while maintaining methodological rigor through triangulation. The framework captures both clinical and ethical dimensions of healthcare under siege, serving epidemiological accuracy and moral communication simultaneously. Humanitarian policy implications include recognizing resource restrictions as both physical harm and epistemic injustice, necessitating interventions that address material needs and communicative capacity.

Future research should examine documentation practices of local Palestinian health organizations to complement institutional perspectives. Cross-cultural comparisons of health crisis communication could identify patterns in credibility construction across conflict zones. Studies of international audience interpretation of health documentation would clarify relationships between communication and humanitarian response. Research on conflict medicine should explore how health workers balance clinical practice with moral testimony in diverse geopolitical contexts. These directions would advance understanding of health documentation's role in struggles for recognition and justice under structural violence.

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